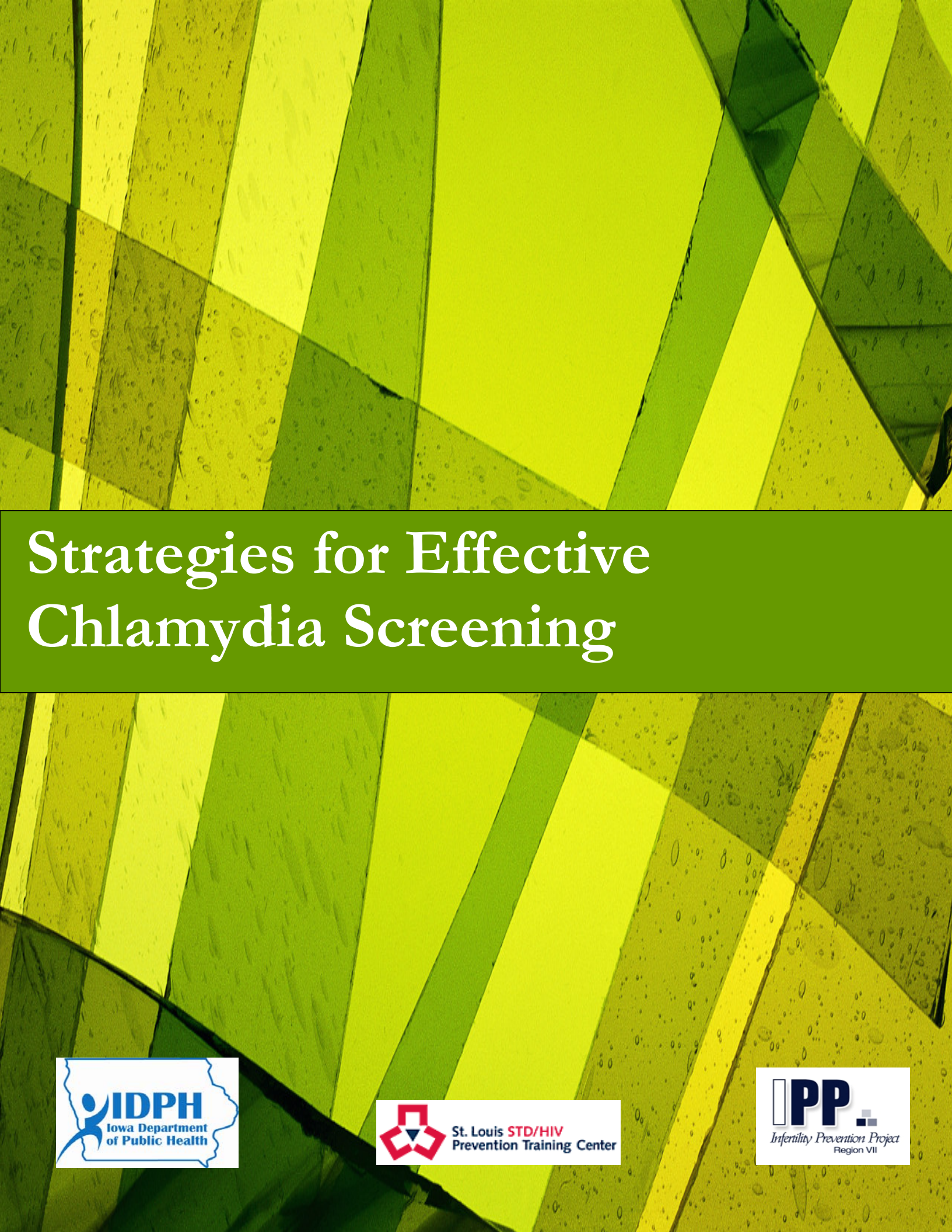


Strategies for Effective Chlamydia Screening

IDPH Iowa Department of Public Health

St. Louis STD/HIV Prevention Training Center

IPP Infertility Prevention Project Region VII

Iowa Department of Public Health
Promoting and Protecting the Health of Iowans

Thomas Newton, MPP, REHS
Director

Chester J. Culver
Governor

Patty Judge
Lt. Governor

August 18, 2008

Dear Colleague:

The Iowa Department of Public Health (IDPH) STD Program has partnered with the Region VII Infertility Prevention Project (IPP) and the Saint Louis STD/HIV Prevention Training Center (PTC) to bring you "Strategies for Effective Chlamydia Screening". This educational toolkit is aimed at increasing health care providers' knowledge and skills to screen and prevent transmission for Chlamydia and other related infections in adolescents and young adults in an office-based setting.

The Centers for Disease Control and Prevention (CDC), U.S. Preventive Services Task Force (USPSTF), and leading medical organizations, including the American Academy of Pediatrics (AAP), the American Academy of Family Planning Physicians (AAFPP), the American College of Obstetricians and Gynecologists (ACOG), and the American Medical Association, all recommend routinely screening all sexually active women under the age of 26 for Chlamydia and gonorrhea. Annual Chlamydia screening is a Health Care Effectiveness Data Information Set (HEDIS) quality assurance measure. This toolkit was created to assist health care providers in confidential screening for Chlamydia and other related infections.

The "Strategies for Effective Chlamydia Screening" Toolkit includes:

- A sexual history questionnaire and accompanying provider information
- CDC Chlamydia Screening recommendations
- IDPH Communicable Disease Reporting Requirements
- Minor Consent guidance for STDs and HIV
- *Neisseria gonorrhoeae* and *Chlamydia trachomatis* laboratory testing information
- Patient education materials
- Confidentiality Tips
- Guidance on partner management options
- Free CME's

The STD Program staff look forward to working with your practice on this collaborative quality improvement activity to increase Chlamydia screening and the quality of care for Iowa's young patients.

Sincerely,

Karen Thompson,
STD Program Manager

Kenneth Soyemi, MD, MPH
Deputy State Epidemiologist

The *"Strategies for Effective Chlamydia Screening"* toolkit was possible because of contributions from the following individuals and entities:

Primary Contributor Acknowledgements:

- Heather Adams, JD – Assistant Attorney General, Iowa Attorney General's Office
- Colleen Bornmueller, BS – Iowa Infertility Prevention Project Coordinator, Family Planning Council of Iowa
- Kenneth Cheyne, MD – Director of Pediatric Education, Adolescent Medicine, Blank Children's Hospital
- Karla Johnson, MSPH – Executive Director, Region VII Infertility Prevention Project, Development Systems, Inc.
- Mary Jones, BSEMS, MA – Deputy Director, Iowa Department of Public Health
- Elizabeth Raasch, BA – STD Program Spring 2008 Intern, Iowa Department of Public Health
- Delores Rother, MPH – Program Manager, St. Louis STD/HIV Prevention Training Center
- Kenneth Soyemi, MD, MPH – Deputy State Epidemiologist, Iowa Department of Public Health
- Rick Steece, PhD, D(ABMM) – National Chlamydia Laboratory Coordinator, Centers for Disease Control and Prevention
- Bradley Stoner, MD, PhD – Medical Director, St. Louis STD/HIV Prevention Training Center
- Karen Thompson, BS – STD Program Manager, Iowa Department of Public Health

Contributor Acknowledgements:

Diane Behle	Iowa Department of Public Health	Linda McQuinn	Iowa Department of Public Health
Shelley Collins	Coventry Health Care of Iowa	Joanne Parker	Iowa Commission on the Status of Women
Mary Costello	Iowa Department of Public Health	Rodney Pederson	Gen-Probe Incorporated
Vickie Evans	Wellmark BlueCross & BlueSheild of Iowa	Ann Rogers	Black Hawk County Health Department
Tanya Fergusen	Council Bluffs City Health Department	Kelly Rooney-Kozak	Iowa Department of Public Health
Carol Hausrath	Roche Diagnostic Corporation	Rocco Russo	Blank Childrens Hospital
Lisa James	University of Iowa Student Health Center	Vickie Smith	Linn County Health Department
Sandy Jirsa	University Hygienic Laboratory	Brenda Sperry	University of Iowa Student Health Center
Lori Kramer	Medical Associates Health Plan	Gina Spinler	Iowa Department of Public Health
Betty Krones	Cerro Gordo County Health Department	Rachel Stolz	Council Bluffs City Health Department
Tracy Kueter	Sioux Valley Health Plan	Roma Taylor	Scott County Health Department
Ann Laros	University of Iowa Student Health Center	Dennis Troy	Becton-Dickinson and Company
Joe Lerberg	Iowa Department of Human Services	Kristin VanGilder	Coventry Health Care of Iowa
Jodie Liebe	Iowa Department of Public Health	Dan Weakly	Siouxland District Health Department
Heather Marthers	Women's Health of Washington	Shannon Wood	Iowa Department of Public Health
Mary McCann	Polk County Health Department	Judy Yu	Abbott Molecular Incorporated

Financial Acknowledgements:
This educational activity was made possible by a grant from the Development Systems, Inc.
Grant number: FPTPA700-25-29-00.

Special Acknowledgements:
The Primary Contributors are pleased to recognize Elizabeth Raasch, STD Program Spring 2008 Intern, without whom, this project would not have been possible.

The Goal **of this toolkit is to increase health care providers' knowledge and skills to prevent and screen for Chlamydia and other related infections in adolescents and young adults in an office-based setting.**

CME Objectives:

After reviewing and completing the educational activity, participants should be able to:

- Identify the signs and symptoms of Chlamydia infection
- Provide care for Chlamydia infection in accordance with current testing and treatment guidelines
- Recognize trends and current epidemiology of Chlamydia in Iowa
- Understand the current factors and characteristics of Chlamydia infection and partner management in Iowa
- Comply with the legal requirements for practitioners for testing, treatment, and reporting Chlamydia, other STDs, and HIV/AIDS in Iowa
- Appreciate the issues of Gonorrhea co-morbidity

Accreditation Statement:

This activity has been planned and implemented in accordance with the Essentials Areas and Policies of the Missouri State Medical Association through the joint sponsorship of the St. Louis STD/HIV Prevention Training Center at Washington University in Saint Louis, Missouri, Development Systems, Incorporated, and the Iowa Department of Public Health. The Saint Louis STD/HIV Prevention Training Center is accredited by the Missouri State Medical Association to provide continuing education for physicians.

Designation Statement:

The Saint Louis STD/HIV Prevention Training Center designates this educational activity for a **maximum of 2.0 AMA PRA™ Category 1 credit.** Physicians should only claim credit commensurate with their participation in the activity.

- The estimated time to complete this educational activity is: **Two Hours**
- Expiration Date for no-cost CME's for this activity: **September, 2009**
- This toolkit was last reviewed on August 22, 2008. The next review will occur in August, 2009.

Instructions for Obtaining CME Credit:

- Read all of the educational materials included in this toolkit
- Complete the Post-Intervention Questionnaire using the answer sheet provided.
- Complete the evaluation questions at the bottom of the Post-Intervention Questionnaire sheet provided.
- Send the Post-Intervention Questionnaires to:

Deloris Rother, MPH, Manager
Prevention Training Center
St. Louis STD/HIV Prevention Training Center
Washington University School of Medicine
660 S. Euclid Avenue, Campus Box 8051
St. Louis, MO 63110-1093
Telephone: (314) 747-0294
FAX: (314) 362-1872
Std/hiv@im.wustl.edu

- A certificate of credit will be mailed to you.
- Retain a copy of your certificate for your records.

For any questions or comments concerning this toolkit, please contact:
The Iowa Department of Public Health STD Program
www.idph.state.ia.us/adper/std_control.asp
515-281-4936 or 515-281-3031

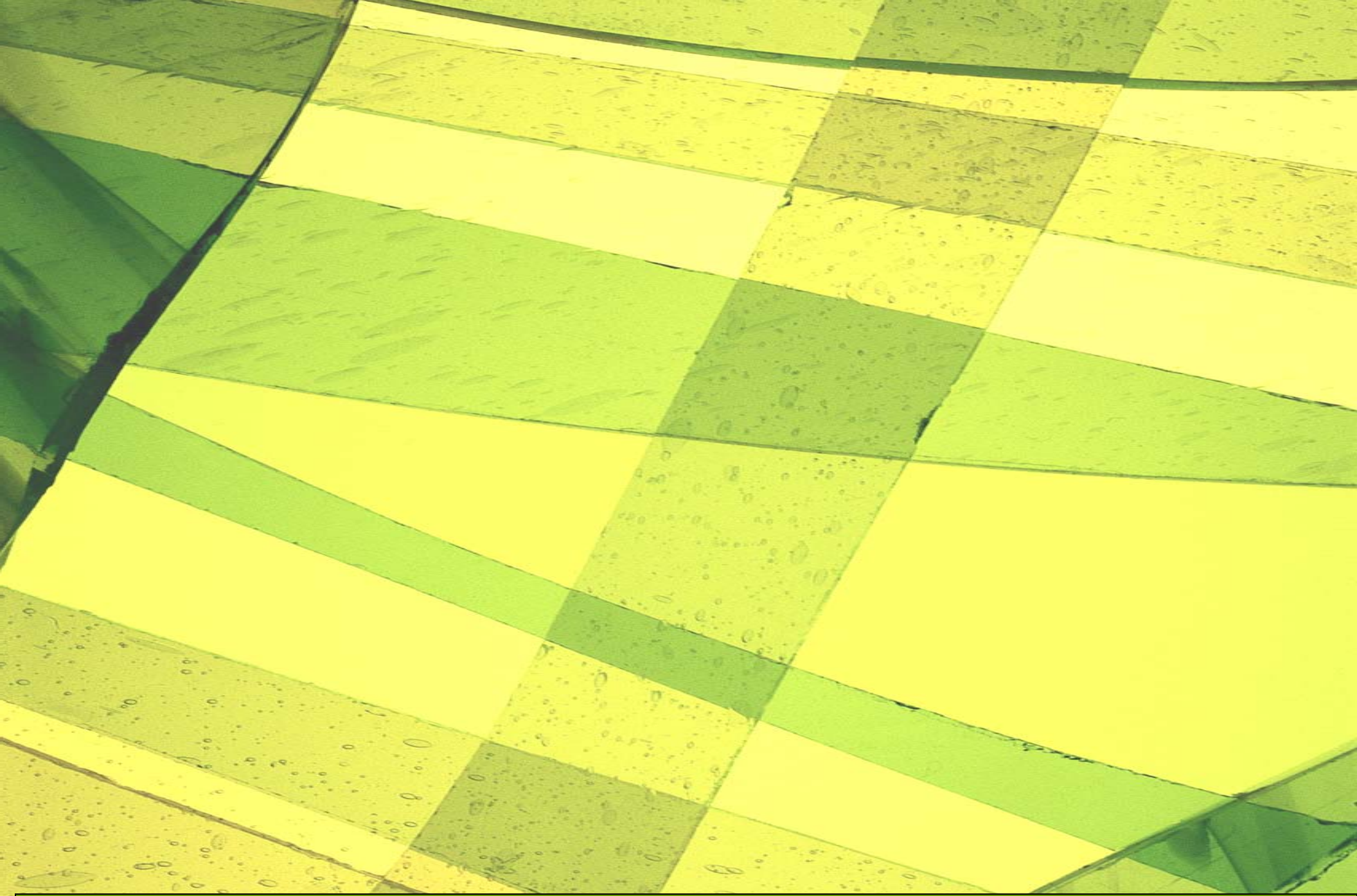
Table of Contents

Printable Handouts

The entire toolkit is printable. The following pages are reference materials that you may want to print frequently for reference or to hand out to patients.

Web site Links

Saint Louis STD/HIV Prevention Training Center Std/hiv@im.wustl.edu
Iowa Dept of Public Health: STD Program www.idph.state.ia.us/adper/std_control.asp
Centers for Disease Control and Prevention (CDC) www.cdc.gov/std
American Social Health Association (ASHA) www.ashastd.org
National Committee for Quality Assurance (NCQA) www.ncqu.org
Iowa General Assembly www.legis.state.ia.us
Iowa Department of Human Services www.dhs.state.ia.us
Youth Law Center www.ylc.org
National Center for Youth Law www.youthlaw.org
Youth Risk Behavior Surveillance System www.cdc.gov/HealthyYouth/yrbs/index.htm
Behavioral Risk Factor Surveillance System www.cdc.gov/brfss
CDC Treatment Guidelines www.cdc.gov/std/treatment
Urban Dictionary www.urbandictionary.com
University Hygienic Laboratory www.uhl.uiowa.edu



Chlamydia Screening Criteria

Chlamydia Screening Criteria

The following section will take you through:

- The problem with Chlamydia and the Epidemiology of Chlamydia in Iowa
- The signs and symptoms of Chlamydia and a likely co-infection, Gonorrhea
- The screening criteria for Chlamydia
- Chlamydia Screening Maps

The Problem With Chlamydia

WHAT?

Chlamydia, caused by the bacteria *Chlamydia trachomatis*, is the most common bacterial sexually transmitted disease in the United States. It is estimated that there are 3 to 5 million cases of Chlamydia infection that occur each year. However, many of these cases are left undetected and untreated since up to 75% of women and 50% of men are asymptomatic.

Untreated and undetected Chlamydia can lead to:

- Pelvic Inflammatory Disease (PID), ectopic pregnancy, and infertility in women
- Urethritis in women and men
- Epididymitis in men
- Increased risk of acquiring and/or spreading HIV infection ***(Individuals are 2 to 5 times more likely to become infected with HIV if exposed when infected with an STD)***
- Passing the infection to a newborn at birth if the mother is infected causing conjunctivitis and pneumonia in the child

WHO?

In the last ten years, there has been a **67% increase** in Chlamydia cases in Iowa
Chlamydia is most commonly found among sexually active individuals ages 15-25.
Other risk factors include:

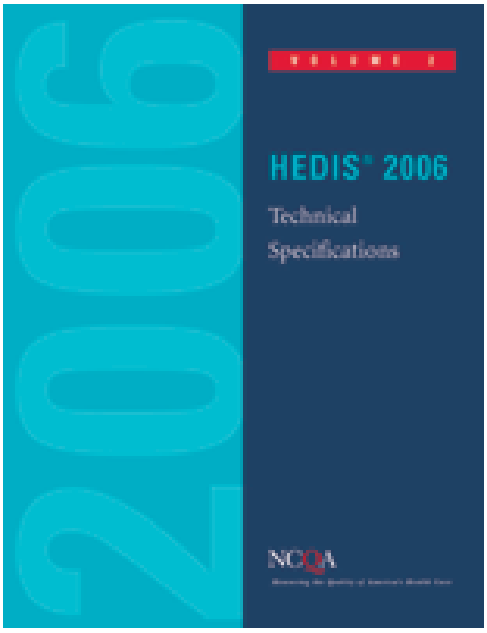
- Unprotected sex
- Incorrect or lack of condom use
- New sex partner or multiple sex partners
- Past history of STDs

HOW?

Screening all sexually active women between the ages of 15 and 25 for Chlamydia is recommended by the Centers for Disease Control and Prevention (CDC) and the U.S. Preventive Services Task Force and is included as a HEDIS (Health Care Effectiveness Data and Information Set) performance measurement expectation. **When possible, screening should be performed among all sexually active men and women.** Screening is an effective and cost-saving approach because it stops the infection from spreading and reduces the risk of Chlamydia's serious complications, such as infertility.

What is HEDIS?

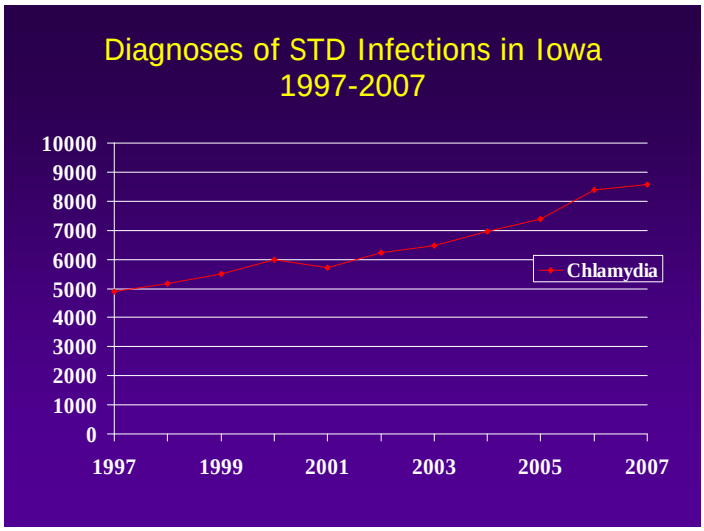
HEDIS is a set of performance measures that are voluntarily reported by health plans and used by the National Committee for Quality Assurance (NCQA) to measure the quality of care and level of service in health plans. The HEDIS Chlamydia Screening Measure estimates the proportion of sexually active females ages 15 to 24 who had at least one test for Chlamydia during the previous year as a plan member of Medicaid or a commercial health plan. Since the measure was introduced in 2000, reports have shown a persistently low proportion of eligible females who were Chlamydia-tested, and it is substantially lower compared to other reports of preventive and therapeutic services measured by HEDIS. However, increases in screening have been seen in women who receive care from providers participating in accredited health plans.

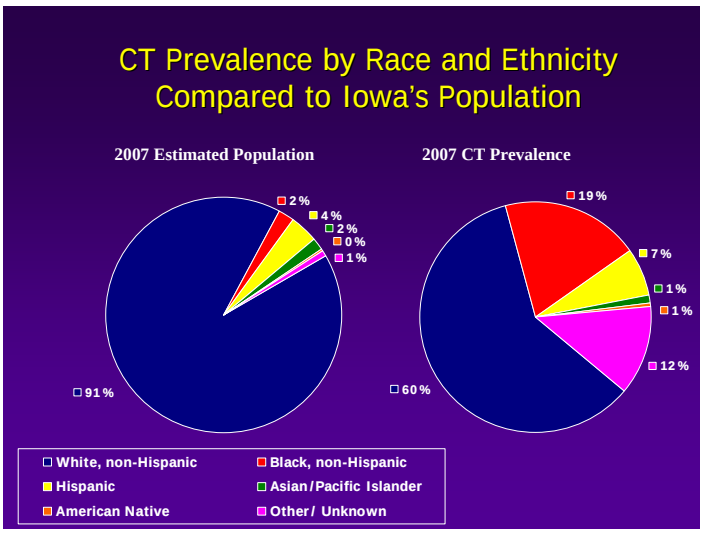


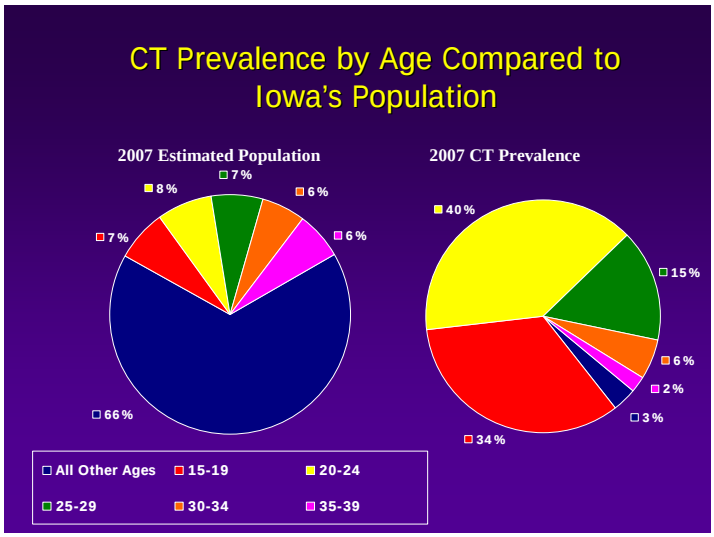
Epidemiology of Chlamydia in Iowa

In the last 10 years, the number of reported Chlamydia infections in Iowa has increased over 67% to a record high of 8,643 cases. The Centers for Disease Control and Prevention (CDC) estimates that about 40% of Chlamydia infections remain undiagnosed and untreated each year. This means that in 2007, over 3,400 infections went undiagnosed and untreated in Iowa. Many of these cases are due to partners not being aware of exposure and/or being unable to seek testing and treatment. In fact, more than 11% of reported Chlamydia and Gonorrhea infections were repeat infections due to lack of partner treatment and over 17% of persons known to be exposed to STDs were unable to seek testing and treatment. In 2007, more than 37% of Iowans reported to have Chlamydia infection were co-infected with Gonorrhea Chlamydia (CT) is most prevalent in young persons aged 15-24 years old which make up 74% of reported infections. Chlamydia is also disproportionate in Blacks and Hispanics who, together, make up 26% or reported infections while only accounting for 8% of Iowa's population.

For more information on the prevalence of STDs in Iowa, please visit:
http://www.idph.state.ia.us/adper/std_control.asp







Signs and Symptoms of Chlamydia

Most people have no symptoms of Chlamydia until complications such as pelvic inflammatory disease, ectopic pregnancy, infertility, urethritis or acute epididymitis arise. If signs and symptoms of Chlamydia are present, they usually begin 7 to 21 days after exposure and include the following:

Symptoms for Women:

- Many women have no symptoms
- Abnormal vaginal bleeding, discharge, or itching
- Burning or pain during urination
- More pain than usual during periods
- Cramps and pain in lower abdomen
- Anal discomfort, itching, or discharge

Symptoms for Men:

- Many men have no symptoms
- Watery or thin white discharge from penis
- Burning or pain during urination or bowel movement
- Anal discomfort, itching or discharge

Signs and Symptoms of Gonorrhea

In 2007, 37% of Iowans reported to have Chlamydia infection were co-infected with Gonorrhea. Public health systems in Iowa provide dual testing for Chlamydia and Gonorrhea. While this toolkit is mainly specific for Chlamydia, most of the information may also be applied to testing and treatment of Gonorrhea as well. Most people have no symptoms of Gonorrhea until complications such as pelvic inflammatory disease, ectopic pregnancy, infertility, infection in joints, lesions on the skin, or acute epididymitis arise. If signs and symptoms of Gonorrhea are present, they usually begin 2 to 7 days after exposure and include the following:

Symptoms for Women:

- Many women have no symptoms
- Abnormal vaginal bleeding, discharge or itching
- Burning or pain during urination or bowel movement
- More pain than usual during periods
- Cramps and pain in lower abdomen
- Anal discomfort, itching or discharge

Symptoms for Men:

- Many men have no symptoms
- Thick, white or yellow discharge (pus) from penis
- Burning or pain during urination or bowel movement
- Anal discomfort, itching or discharge

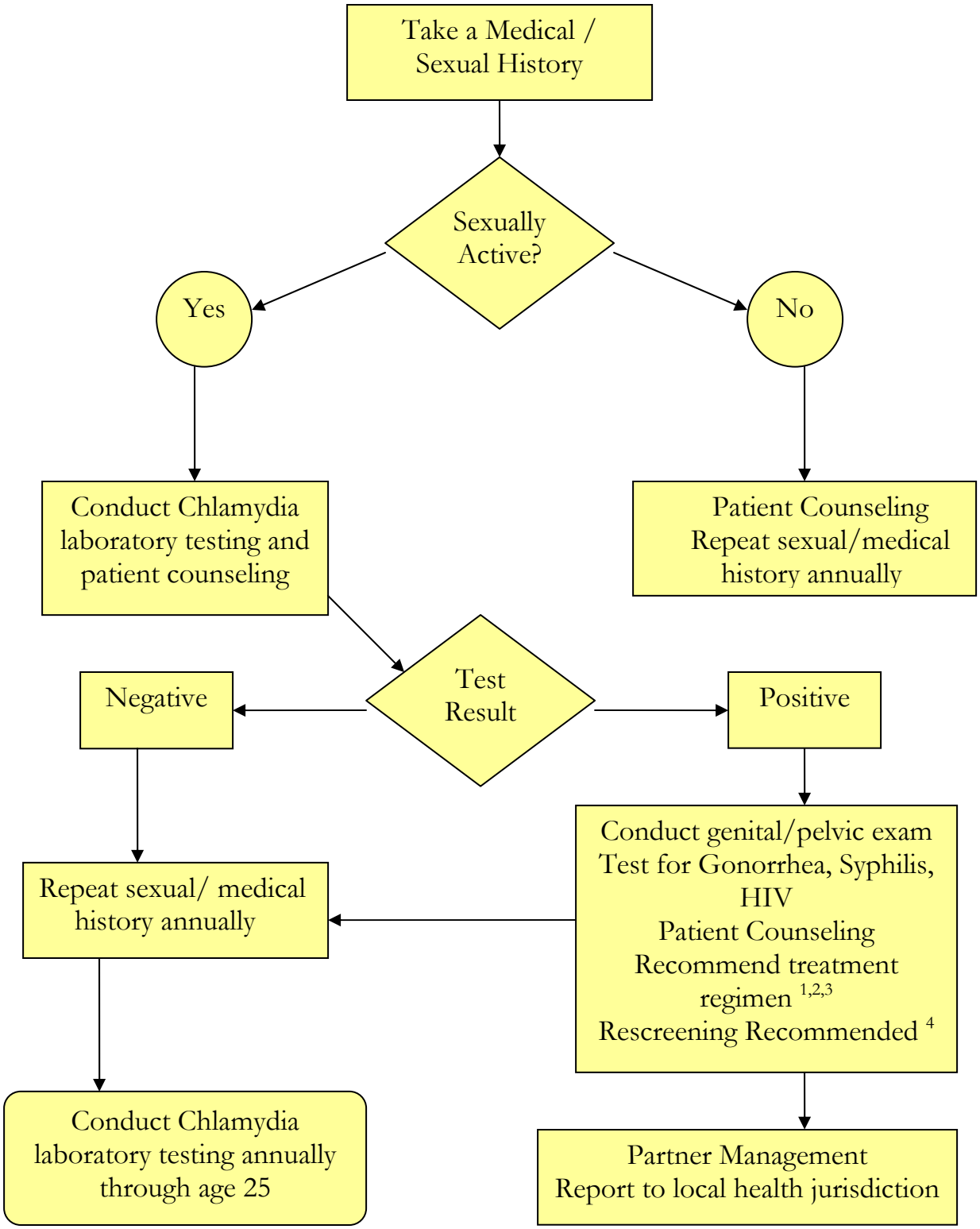
Screening in Iowa

For asymptomatic, non-pregnant females: Routine annual testing for sexually active individuals ages 15-25. If a positive case is found, the patient should be treated and retested approximately 3-4 months after treatment. The patient should continue screening annually until they are age 25 or have a decreased risk of infection.

For uncomplicated symptomatic non-pregnant females and males: Conduct testing if signs/symptoms (as listed above) are indicative of Chlamydia. If positive, the patient should be treated and retested approximately 3-4 months after treatment. Providers also are strongly encouraged to retest all patients treated for Chlamydia infection whenever they next seek medical care within the following 3–12 months, regardless of whether the patient believes that his or her sex partners were treated.

For pregnant females: Conduct testing at first prenatal visit and rescreen if positive 3 weeks after completion of therapy to ensure therapeutic cure, considering the sequelae that might occur in the mother and neonate if the infection persists.

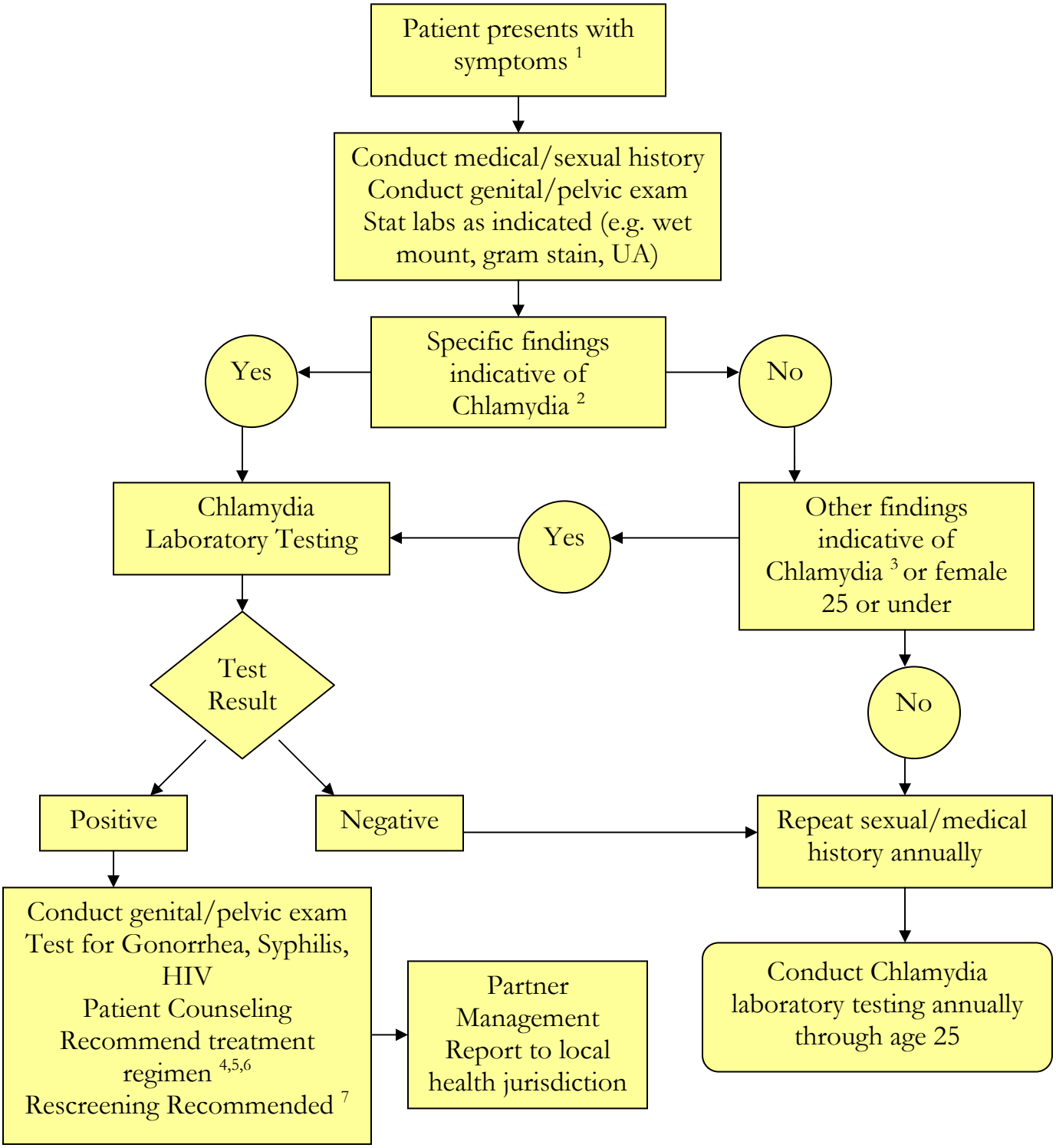
Chlamydia Screening Map for Asymptomatic Non-Pregnant Females



May 2008

1 Azithroymycin dose: 1 gram p.o., single dose
2 Doxycycline dose: 100 mg p.o. BID for 7 days
3 Alternative treatment regimen: Erythromycin base 500 mg p.o. QID for 7 days or Erythromycin ethylsuccinate 800 mg p.o. QID for 7 days or Ofloxacin 300 mg p.o. BID for 7 days or Levofloxacin 500 mg p.o. QD for 7 days
4 Because Chlamydia reinfection is common, it is recommended that rescreening of infected females be performed 3-4 months after treatment

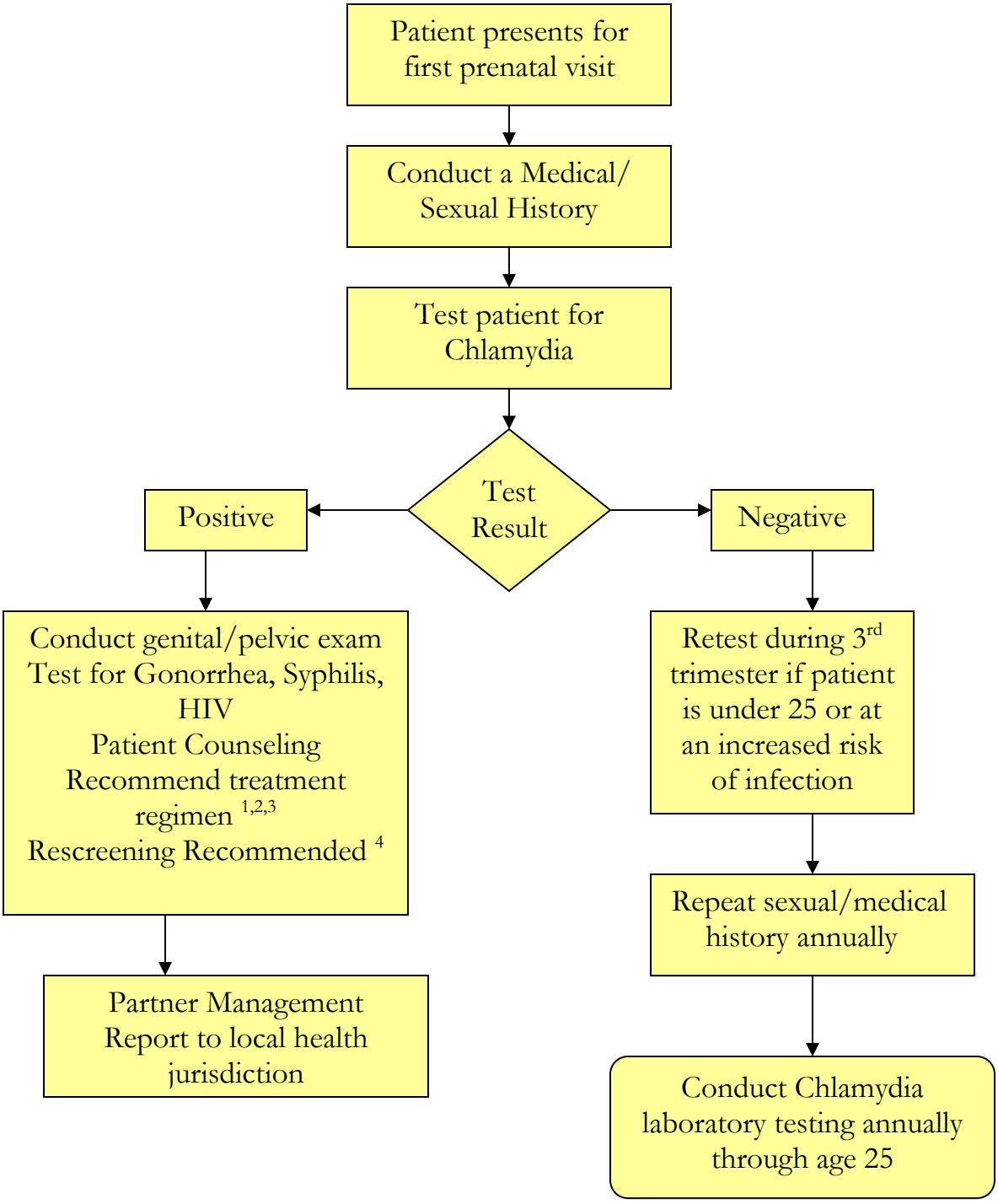
Chlamydia Screening Map for Uncomplicated Symptomatic Non-Pregnant Females and Males



May 2008

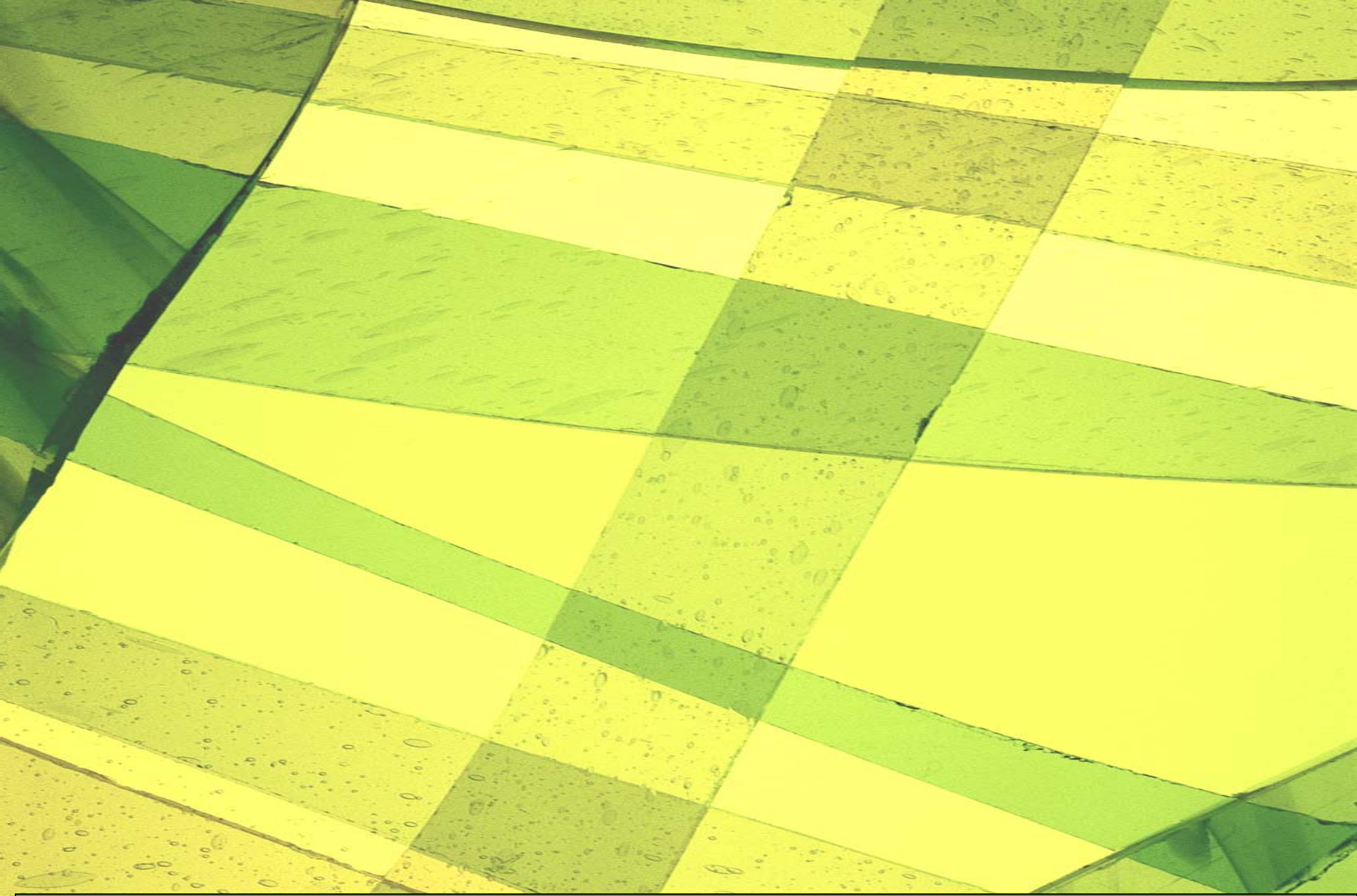
1 Symptoms: Females- abnormal vaginal discharge, abnormal vaginal bleeding or dysuria; Males- urethral discharge or dysuria
2 Females- mucopurulent cervicitis or cervical friability; Males- urethral discharge or evidence of urethritis by gram stain or UA
3 Females: abnormal vaginal discharge of unknown etiology; abnormal vaginal bleeding of unknown etiology or dysuria without evidence of urinary tract infection
4 Azithroymycin dose: 1 gram p.o., single dose
5 Doxycycline dose: 100 mg p.o. BID for 7 days
6 Alternative treatment regimen: Erythromycin base 500 mg p.o. QID for 7 days or Erythromycin ethylsuccinate 800 mg p.o. QID for 7 days or Ofloxacin 300 mg p.o. BID for 7 days or Levofloxacin 500 mg p.o. QD for 7 days
7 Because Chlamydia reinfection is common, it is recommended that rescreening of infected females be performed 3-4 months after treatment

Chlamydia Screening Map for Pregnant Females



May 2008

1 Azithroymycin dose: 1 gram p.o., single dose
2 Amoxicillin dose: 500 mg p.o. TID for 7 days
3 Alternative treatment regimen: Erythromycin base 500 mg p.o. QID for 7 days or Erythromycin base 250 mg p.o. QID for 14 days or Erythromycin ethylsuccinate 800 mg p.o. QID for 7 days or Erythromycin ethylsuccinate 400 mg p.o. QID for 14 days
4 Because Chlamydia reinfection is common and there is a risk of transmitting Chlamydia to a newborn infant, it is recommended that rescreening of infected females be performed 3 weeks after treatment or during the third trimester if the mother is at an increased risk of infection (under 25 years, new or multiple partners, etc)



Screening Tests for Chlamydia

Screening Test for Chlamydia

The following section will take you through:

- The recommended diagnostic tests for Chlamydia
- The advantages and disadvantages of each test type

Diagnostic Testing of Chlamydia

There are many different screening tests for Chlamydia:

- Culture
- DNA probe
- Direct Fluorescent Antibody (DFA)
- Enzyme Immunoassay (EIA)
- Nucleic Acid Amplified Test (NAAT)

Nucleic Acid Amplified Tests (NAAT) are recommended for Chlamydia testing because they are highly sensitive and specific. They also permit urine as a specimen, therefore avoiding a clinical pelvic exam. However, if a pelvic exam is scheduled, indicated or part of a routine exam, an endocervical NAAT is recommended. When performing a NAAT urine-based test, the patient should not have urinated for one hour prior to collection. If a patient shows signs or symptoms of infection, a urine based test should not be used and a swab test should be used instead. Generally, NAAT tests can check for both Chlamydia and Gonorrhea at the same time.

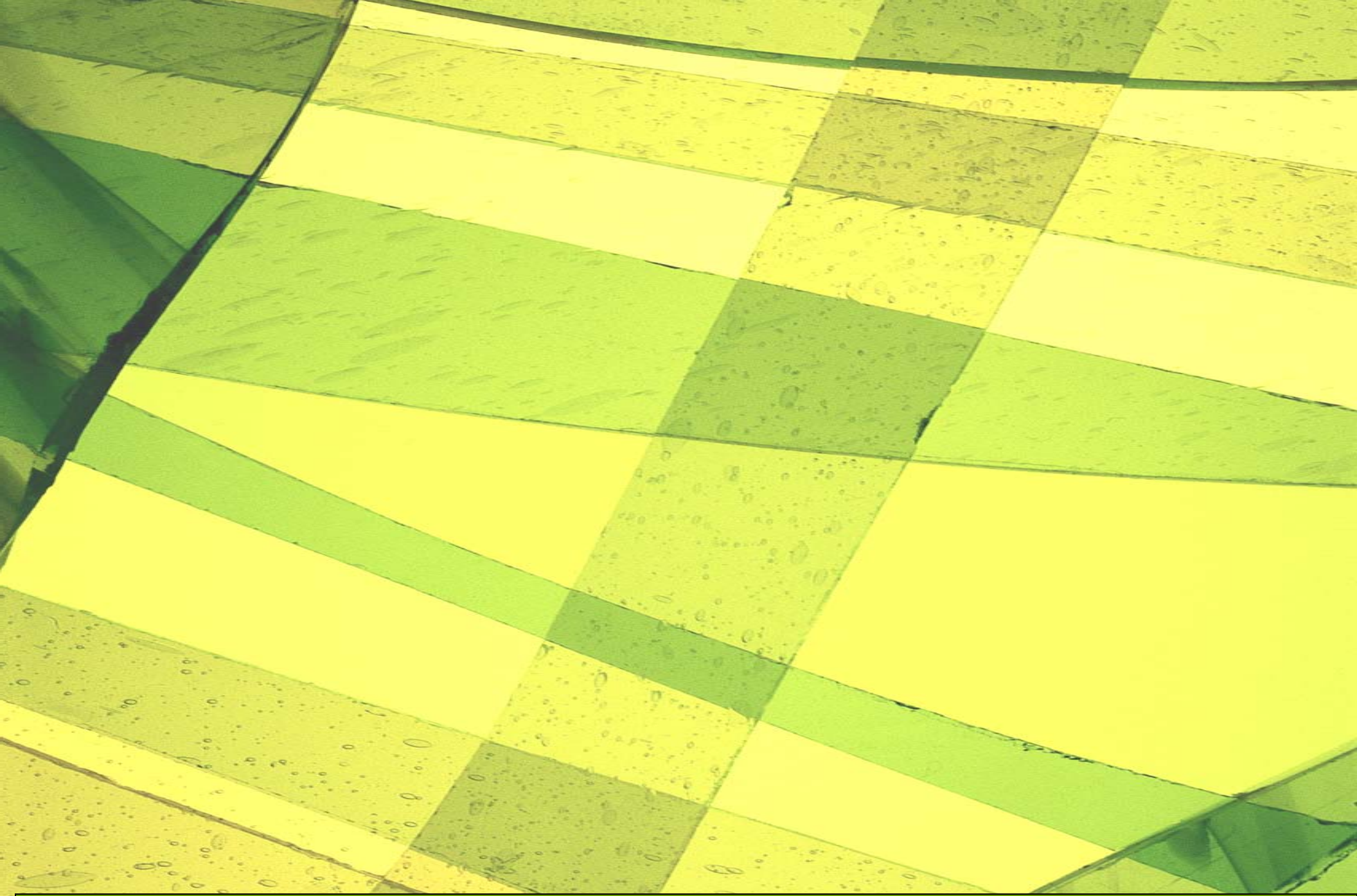
NAAT testing is not FDA approved for rectal or pharyngeal specimens.

The chart on the next page provides information about the current test technologies available for Chlamydia.

Which test is right for your clinic?

	Nucleic Acid Amplification Technology	Cell Culture	Direct Fluorescent Antibody (DFA)	Enzyme Immunoassay (EIA)	Nucleic Acid Probe (DNA Probe)
Sensitivity	95-98%	40-70%	65-75%	60-70%	60-75%
Specificity	>99%	>99%	97-99%	95-99%	97-99%
Test Advantages	• Non-invasive urine specimens in addition to genital swabs. • **Most sensitive** • Dual testing for Chlamydia and Gonorrhea available • Rapid turn around time in lab • No refrigeration during transport required • Effective for large scale screening	• Recommended test for medico-legal purposes • Many types of specimens (endocervical, urethral, rectal, ocular, etc.)	• Internally controlled for specimen adequacy • No refrigeration during transport required	• Less expensive than NAATs • Rapid turn around time in lab • No refrigeration during transport required • Effective for large scale screening	• Less expensive than NAATs • Dual testing for Chlamydia and Gonorrhea • Rapid turn around time in lab • No refrigeration during transport required • Effective for large scale screening
Test Disadvantages	• More expensive • Needs high degree of technical skill • May require special facilities or clean areas	• Less sensitive than NAATs • Longer turn around time (2-3 days) • Technically difficult (storage, transport, temperature) • Comparatively expensive • Only tests for Chlamydia	• Less sensitive than NAATs	• Less sensitive than NAATs • Only tests for Chlamydia • Supplemental testing recommended	• Less sensitive than NAATs • Supplemental testing recommended

Table Contents Provided by Rick Steece, PhD, D(ABMM), National Chlamydia Laboratory Coordinator, Centers for Disease Control and Prevention, May 2008.



Iowa Law and Confidentiality Issues

Iowa Law and Confidentiality Issues

The following section will take you through:

- Iowa Code specific to the control of STDs
- The HIPAA Privacy Rule in Iowa
- Adolescents and the Iowa Code
- Overview of Sexual Abuse Code
- Creating a Youth Friendly and Confidentiality Conscious environment

Iowa Code for Control of STDs

Iowa Code chapter 139A: Communicable and Infectious Diseases and Poisonings is the section of Iowa Code that contains language specific to STD reporting and practices. Some frequently referenced sections are highlighted here. The full code can be viewed at: http://www.legis.state.ia.us by typing 139A into the "Quick Find" search engine titled "Bills and Iowa Code".

Section 139A.30 Confidential Reports
"Reports to the department which include the identity of persons infected with a sexually transmitted disease or infection, and all such related information, records, and reports concerning the person, shall be confidential and shall not be accessible to the public. However, such reports, information, and records shall be confidential only to the extent necessary to prevent identification of persons named in such reports, information, and records; the other parts of such reports, information, and records shall be public records. The preceding sentence shall prevail over any inconsistent provision of this subchapter."

Section 139A.31 Report to Department
"Immediately after the first examination or treatment of any person infected with any sexually transmitted disease or infection, the health care provider who performed the examination or treatment shall transmit to the department a report stating the name of the infected person, the address of the infected person, the infected person's date of birth, the sex of the infected person, the race and ethnicity of the infected person, the infected person's marital status, the infected person's telephone number, if the infected person is female, whether the infected person is pregnant, the name and address of the laboratory that performed the test, the date the test was found to be positive and the collection date, and the name of the health care provider who performed the test. However, when a case occurs within the jurisdiction of a local health department, the report shall be made directly to the local health department which shall immediately forward the information to the department. Reports shall be made in accordance with rules adopted by the department. Any person filing a report of a sexually transmitted disease or infection who is acting reasonably and in good faith is immune from any liability, civil or criminal, which might otherwise be incurred or imposed as a result of such report. "

Section 139A.32 Examination results from laboratory- report.
"A person in charge of a public, private, or hospital clinical laboratory shall report to the department, on forms prescribed by the department, results obtained in the examination of all specimens which yield evidence of or are reactive for those diseases defined as sexually transmitted diseases or infections, and listed in the Iowa administrative code. The report shall state the name of the infected person from whom the specimen was obtained, the address of the infected person, the infected person's date of birth, the sex of the infected person, the race and ethnicity of the infected person, the infected person's marital status, the infected person's telephone number, if the infected person is female, whether the infected person is pregnant, the name and address of the laboratory that performed the test, the laboratory results, the test employed, the date the test was found to be positive and the collection date, the name of the health care provider who performed the test, and the name and address of the person submitting the specimen."

Section 139A.35 Minors

"A minor shall have the legal capacity to act and give consent to provision of medical care or services to the minor for the prevention*, diagnosis, or treatment of a sexually transmitted disease or infection by a hospital, clinic, or health care provider. Such medical care or services shall be provided by or under the supervision of a physician licensed to practice medicine and surgery, osteopathy, or osteopathic medicine and surgery, a physician assistant, or an advanced registered nurse practitioner. Consent shall not be subject to later disaffirmance by reason of such minority. The consent of another person, including but not limited to the consent of a spouse, parent, custodian, or guardian, shall not be necessary."

*The word "prevention" was added to this section in 2007 to allow for minors seeking STD-related immunizations such as an HPV or Hepatitis vaccine.

Section 139A.25 Penalties

"1. Unless otherwise provided in this chapter, a person who knowingly violates any provision of this chapter, or the rules of the department or a local board, or any lawful order, written or oral, of the department or board, or of their officers or authorized agents, is guilty of a simply misdemeanor.

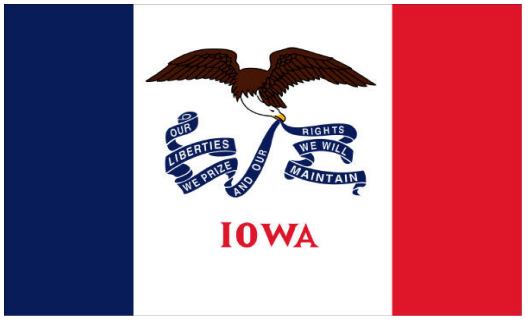
2. Notwithstanding subsection 1, an individual who repeatedly fails to file any mandatory report specified in this chapter is subject to a report being made to the licensing board governing the professional activities of the individual. The department shall notify the individual each time that the department determines that the individual has failed to file a required report. The department shall inform the individual in the notification that the individual may provide information to the department or explain or dispute the failure to report.

3. Notwithstanding subsection 1, a public, private, or hospital clinical laboratory that repeatedly fails to file a mandatory report specified in this chapter is subject to a civil penalty of not more than one thousand dollars per occurrence. The department shall not impose the penalty under this subsection without prior notice and opportunity for hearing."

Section 139A.41 Chlamydia and Gonorrhea*

"Notwithstanding any other provision of law, a physician, physician assistant, or advanced registered nurse practitioner who diagnoses a sexually transmitted Chlamydia or Gonorrhea infection in an individual patient may prescribe, dispense, furnish, or otherwise provide prescription oral antibiotic drugs to that patient's sexual partner or partners without examination of that patient's partner or partners. If the infected individual patient is unwilling or unable to deliver the medication to a sexual partner or partners, a physician, physician assistant, or advanced registered nurse practitioner may dispense, furnish, or otherwise provide the prescription oral antibiotic drug to the department or local disease prevention investigation staff for delivery to the partner or partners."

*As of this writing, the section above is not yet included in the online version of the Iowa Code. To view this language, use the same website: http://www.legis.state.ia.us and type SF2177 in the "Quick Find" search engine titled "Bills and Iowa Code".



HIPAA

This memo was originally released in 2003 with the inception of HIPAA to guide providers in understanding confidential reporting of infectious diseases. It was updated with current information in August, 2008.

TO: Iowa Health Care Providers and Clinical Laboratories
FROM: Heather L. Adams, Assistant Attorney General
RE: HIPAA PRIVACY RULES AND IOWA REPORTING REGULATIONS

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires covered entities to obtain consent or authorization from an individual for certain uses and disclosures of identifiable health information. The rule also provides that for certain uses and disclosures consent or authorization is **not** required.

The Privacy Rule expressly permits covered entities to report disease, injury, health conditions, and poisonings to public health authorities without obtaining consent or authorization from the patient. First, although the requirements of HIPAA generally preempt state law, HIPAA provides for certain exceptions to this general preemption rule. One such exception applies when state statute and state administrative rules provide for Athe reporting of disease or injury, . . .or for the conduct of public health surveillance, investigation, or intervention.@ 45 CFR 160.203. Iowa Code chapters 135 and 139A and 641 Iowa Administrative Code chapter 1 require health care providers and laboratories to report all cases of reportable diseases (including all diseases and conditions, syndromes, occupationally related conditions, agriculturally related injuries, and poisonings listed in 641 IAC chapter 1) to the Iowa Department of Public Health (IDPH). Health care providers and laboratories are also required by law to cooperate and assist with disease investigations conducted by the IDPH or by a local public health board or department. 641 IAC 1.4(3). These provisions of law are not preempted by HIPAA and therefore the reporting of this information does not require prior consent or authorization.

HIPAA also provides for a number of Apermitted disclosures,@ i.e. those disclosures of protected health information for which consent or authorization is **not** required. HIPAA authorizes such disclosures Ato the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.@ 45 CFR 164.512(a). HIPAA further authorizes disclosures for public health activities to Aa public health authority that is authorized by law to collect or receive such information for the purposes of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions[.]@ 45 CFR 164.512(b)(1)(i). As discussed above, health care providers and laboratories are required by Iowa law to report certain diseases and conditions, syndromes, occupationally related conditions, agriculturally related injuries, and poisonings to the IDPH. Hence, HIPAA does not require that covered entities obtain consent or authorization prior to releasing reportable disease information to IDPH.

In short, HIPAA provides no legal basis for health care providers or laboratories to refuse to notify IDPH or local health departments of reportable conditions, nor does HIPAA provide a legal basis for health care providers or laboratories to stop cooperating with IDPH or local health departments in the course of disease investigations, follow-up, or surveillance. Disclosures of reportable disease information are legally required and must continue to occur as mandated by state law.

Adolescents and the Iowa Code

According to Iowa Code section 599.1, a minor (an individual younger than 18 years of age) may seek medical care for the following without the permission or knowledge of his/her parents:

- Substance Abuse Treatment **(Section 125.33);**
- STD prevention, testing, and treatment **(Section 139A.35);**
- HIV testing – though if positive, Iowa law requires parent notification **(Section 141A.7);**
- Contraceptive care and counseling, including emergency contraception; and
- Blood donation if 17 years of age or older **(Section 599.6).**

A minor may also consent for evaluation and treatment in a medical emergency or following a sexual assault. However, treatment information cannot be kept confidential from parents.

Even though teenagers and young adults can receive these treatments without their parent's knowledge, it is important to remember parents are a key part of all aspects of a teen's life. Parents and teens should be encouraged to be open and honest with each other when it comes to healthcare decisions.

According to Iowa Code section 252.16, an emancipated minor is one who is married (or was ever married) or is one who:

- Is absent from the parental home with parent consent;
- Is self-supporting, receiving no financial income from parents;
- **AND,** an inconsistent relationship with being a part of the family of the parent exists.

Primary care providers play a key role in adolescent and reproductive health as part of preventive care and health care maintenance. Every state explicitly allows minors to consent for their own health services for STDs. No state requires parental consent for STD care or requires that providers notify parents that a minor has received STD services, except in limited or unusual circumstances.

The only time the confidentiality for minors can be breached is in the case of:

- Suicide threats
- Threat to harm others
- Positive HIV test ***(a consent form for minors is offered on the following page)***
- Medical Emergency or sexual assault

Make certain minors know your office billing procedures. If a parent will receive a bill, the minor should be informed of that policy at the time of testing.

Adolescents also have the right to:

- Opportunities to learn about the cost of medical care, and to ask if they can get care that costs less or is free
- Opportunities to pay for certain services, like STD testing, out of pocket to prevent a mailed bill for services from breaching confidentiality
- Complete information, in words they can understand, about medical care
- Access to information contained on their medical record

Minor's Consent for HIV Testing

I have been advised and understand the nature of the HIV antibody test and what the results would mean.

I understand that:

- HIV is the virus that causes AIDS
- The only way to know if I have HIV is to be tested
- State law protects the confidentiality of test results
- My health care provider will talk with me about notifying my parents and my sex and/or needle-sharing partners of possible exposure, if I test positive.

I hereby authorize the _____ to perform this test.
Agency

I have been advised and understand that if my HIV test is positive, this agency is required to notify my parent or legal guardian of the positive result.

_____	_____	_____
Name of person testing (print)	Signature	Date

_____	_____	_____
Witness (print)	Signature	Date

Overview of Sexual Abuse Code

The following information is from **Iowa Code Chapter 709 Sexual Abuse and Section 726.2 Incest**. The full code can be viewed at http://www.legis.state.ia.us by typing the code number into the "Quick Find" search engine titled "Bills and Iowa Code".

Definitions

- According to **Section 702.5** Child, unless another age is specified, a "child" is any person under the age of fourteen years".
- Sexual acts are deemed "abusive" in the following circumstances:
  by force or against the will of the other
  when consent is gained by threats of violence
  when one is suffering from mental defect or incapacity
  when one is a child (under the age of fourteen)
  when one is a minor and the assailant is five or more years older

Penalties

1st Degree Sexual Abuse **(Section 709.2)** Class "A" Felony

1. Serious injury occurred: a disabling mental illness or bodily injury with substantial risk of death or permanent disfigurement.

2nd Degree Sexual Abuse **(Section 709.3)** Class "B" Felony

1. Display of a deadly weapon.
2. Threats to seriously injure or cause risk of death.
3. The victim is under the age of 12.
4. When aided or abetted by one or more persons.

3rd Degree Sexual Abuse **(Section 709.4)** Class "C" Felony

1. Any sex act that is done by force or against the will of the other.
2. The victim suffers from mental defect or incapacity which precludes giving consent.
3. The victim is under the age of 14.
4. The victim is 14 or 15 and the perpetrator is a member of the same household, or related by blood to the 4th degree, or is four or more years older than the victim.
5. The perpetrator is in a position of authority over the victim and used this authority to coerce the victim: employer, teacher, therapist, minister, etc.

Lascivious Acts with a Child **(Section 709.8)** Class "C" to "D" Felony

Any of the following acts committed by a person that is 16 years of age or older without the child's consent for the purpose of arousing or satisfying the sexual desires of either of them:

a. Fondle or touch the genitals of the child.
b. Permit or cause a child to fondle or touch the person's genitals or pubes.
c. Solicit a child to engage in a sex act or solicit a person to arrange a sex act with a child.
d. Inflict pain or discomfort upon a child or permit a child to inflict pain or discomfort on the person.

Attempted Sexual Abuse **(Section 709.11)**

A committed assault with the intent to commit sexual abuse is penalized as follows:

a. Class "C" Felony if the result is a serious injury.
b. Class "D" Felony if the result is any bodily injury other than a serious injury.
c. Aggravated Misdemeanor if no injury results.

Lascivious Conduct with a Minor **(Section 709.14)** Serious Misdemeanor

It is unlawful for a person over 18 years of age who is in a position of authority over a minor to force, persuade, or coerce a minor with or without consent to disrobe or partially disrobe for the purpose of arousing or satisfying the sexual desires of either of them.

Incest **(Section 726.2)** Class "D" Felony

A person, except a child as defined in section 702.5 (under the age of 14), who performs a sex act with another whom the person knows to be related to the person, either legitimately or illegitimately, as an ancestor, descendant, brother or sister of the whole or half blood, aunt, uncle, niece, or nephew, commits incest.

When and How to place a Mandatory Report…

Always seek counsel from your office's legal representative or a county attorney when there are questions or concerns regarding legal issues. The following resources offer guidance regarding Mandatory Reporting and Child Abuse:

Iowa's Child and Dependent Adult Abuse Hotline:

1-800-362-2178

Iowa Department of Human Services Guide for Mandatory Reporters website PDF:
http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Master/comm164.pdf

Iowa Department of Human Services website:
http://www.dhs.state.ia.us

Iowa Department of Elder Affairs Dependent Adult Abuse website:
http://www.state.ia.us/elderaffairs/advocacy/elderabuse.html

Youth Law Center website:
http://www.ylc.org

National Center for Youth Law website:
http://www.youthlaw.org

Creating a *"TEEN FRIENDLY and CONFIDENTIALITY CONSCIOUS"* Environment…

Many adolescents have concerns related to testing for STDs which can prevent them from seeking information and care. Studies suggest that the reasons for not obtaining care include:

- Access barriers such as no insurance and no transportation
- Concern with privacy and confidentiality
- Inexperience as healthcare consumers
- A belief that the problem would go away
- Fear about discovering that they have an STD
- Fear of HIV/AIDS
- A belief that it is possible to die from a Chlamydial infection

Creating a teen friendly and confidentiality conscious office:

- Offer an atmosphere that is appealing to adolescents (pictures, posters, wallpapers, music and magazines that interest adolescents and reflect their cultures and literacy levels).
- Include décor that reflects the genders, sexual orientations, cultures and ethnicities of your patients. For example, display a rainbow poster that is gay, bisexual, lesbian, and transgender (GBLT) sensitive.
- Make sure that messages can be left on the patient's contact phone number before doing so.
- Always shut the door when discussing anything sensitive, such as sexual history, weight, or substance use.
- Offer after-school hours.
- Describe what procedures you are performing step-by-step and include why each step is necessary.
- Make sure that all information in the form of brochures, pamphlets, etc. is small enough to fit into a purse or wallet.
- Make sure that brochures, pamphlets, etc. can be obtained in private rather than in the waiting room where others will be able to see the information is being gathered.
- Make it clear at the beginning of the appointment that you are required to maintain patient confidentiality, except under very specific circumstances.
- Post an office policy about confidential issues pertaining to youth and their families in public areas.
- Train and educate staff members regarding laws that pertain to adolescents and their right to receive care without parent or guardian consent.
- Keep in mind that communication skills may not reflect the true cognitive and problem-solving abilities.
- Congratulate the patient when they are making healthy choices and decisions.

The following form can assist in making sure patients are contacted in the manner they wish to be contacted in.

Patient Contact Form

Patient Name_____ Birth Date _____
Address _____

Please tell us about the best ways to reach you to talk about your medical care. Check everything that applies:

Today's Date is _____

By mail

- ☐ At the address above
- ☐ At this address

By phone (Make sure to give us the number)

- ☐ Home phone number _____ Can we leave a message (circle): YES NO
- ☐ Cell phone number _____ Can we leave a message (circle): YES NO
- ☐ Beeper number _____ Can we leave a message (circle): YES NO
- ☐ School Clinic number _____ Can we leave a message (circle): YES NO

May we identify ourselves when we call?

- ☐ Yes
- ☐ No

If no, who should we say has called so that you know to call us back? _____
Does it matter whether a guy or girl office assistant makes the call?

- ☐ Yes, girl assistants only
- ☐ Yes, guy assistants only
- ☐ No, it doesn't matter

What are the best times to reach you? _____

If we are unable to reach you according to the plan above, is there someone else we can call who will help us reach you?

- ☐ Yes (provide the name, relationship, and phone number on the line below)

_____

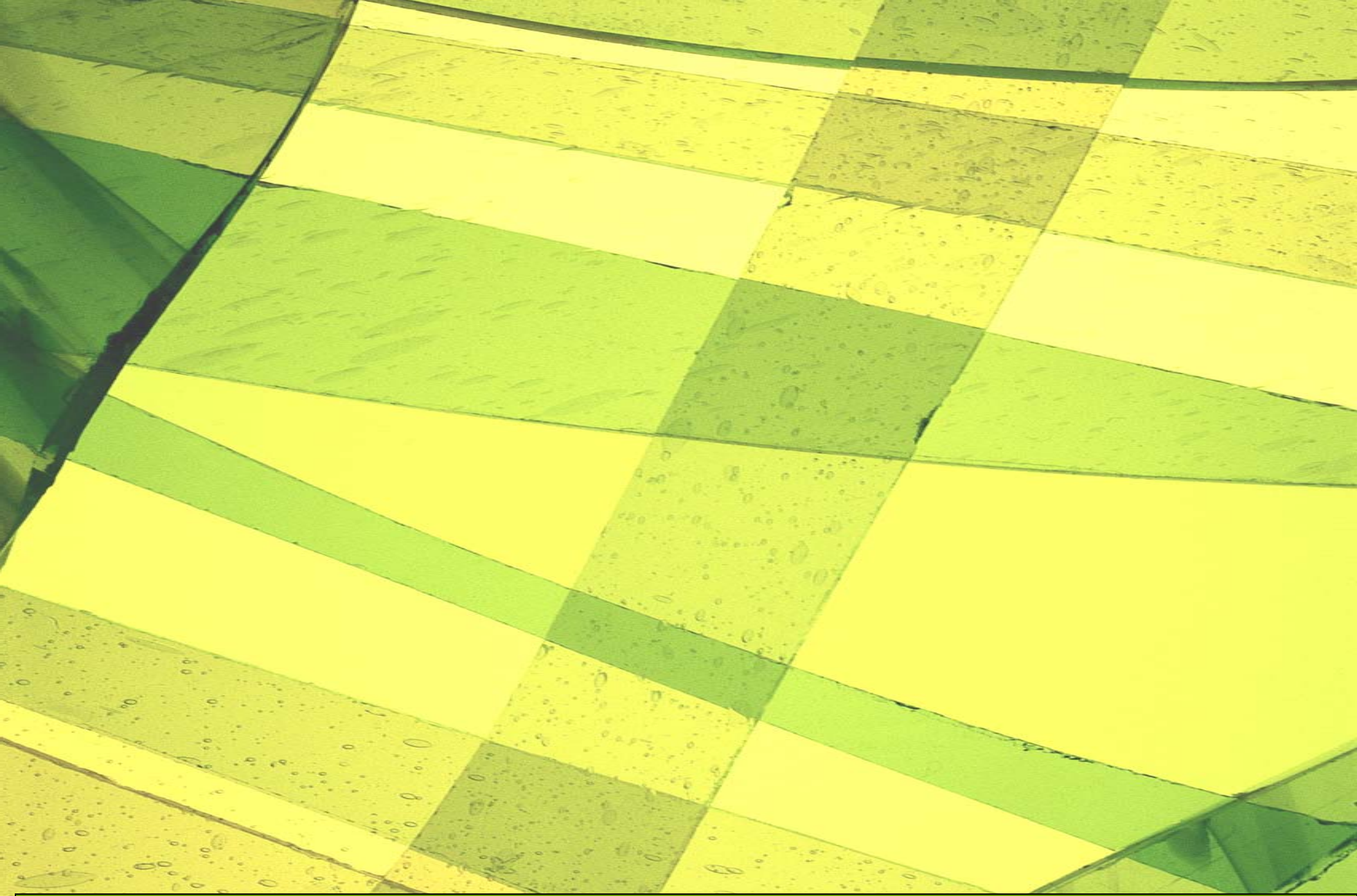
- ☐ No

Is there anything else we should know that will help us give you the best care possible?

_____
_____
_____

If you need to reach us:
Your Doctor's name is _____
Call _____ during office hours _____
Call _____ on weekends or after regular office hours

Our office address is:



Billing and Coding

Billing and Coding

The following section will take you through:

- Ways to widely screen for Chlamydia infection
- Office Billing and the Explanation of Benefits (EOB)
- Billing and Coding to maintain Confidentiality

Screen as widely as possible

Routine Chlamydia screening for sexually active adolescent and young adult females is recommended by several national organizations including the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the U.S. Preventive Services Task Force. Routine screening for males is also important since males are often asymptomatic, and, if sexually active and infected, can unknowingly transmit an infection to a female.

Billing and coding for confidential services is a complex issue. A recent survey of Iowa providers showed that some providers are able to successfully screen or refer patients for screening.

Here's How:

Consider ***"NORMALIZING"*** screenings for Chlamydia and other STDs if questions about billing come up. Screen during annual exams, sports physicals, and during other routine testing.

"We routinely screen teens to make sure we are not missing any problem that was not discussed or disclosed."

OR:

Offer to allow the test to be paid for during that visit and out of pocket. Make sure the patient has the ability to pay for the test in a manner that will not breach confidentiality. This might mean making arrangements for the payments to occur in the exam room.

OR:

Become familiar with local low- or no-cost Family Planning and STD Clinic services.

Go to http://www.idph.state.ia.us/adper/std_control.asp for a **PROVIDER DIRECTORY** of the IDPH STD Program's publicly funded screening sites. The directory is not included in this toolkit since the clinic information changes frequently.

Office Billing and the EOB:

It is important for minors to know that being covered by his or her parents' medical insurance means he or she may need to consent to medical records being shared if they want the insurance to cover testing and treatment. This is a good time to coach a minor to openly communicate with parents about sexual health and behavior.

Most of the major health plans in Iowa were contributors in creating this toolkit. Different health plans in Iowa have differing policies about disclosure of the services on an EOB:

- Some will refer any questions to the provider.
- Some will disclose only to the primary holder of the insurance.
- Some will disclose to a parent if the service was for a member under the age of 18.

ALL *have one thing in common…*

The EOB **DOES NOT** state "Chlamydia Test" or any other specific language about the service provided. The language on the EOB is most likely to be something like "Medical Service" or "Laboratory Service".

The bill from the provider is the documentation most likely to state the specific procedures performed. Check your office policies to be certain what your billing procedures are, and that you are prepared to answer questions regarding the specific services listed on patient bills.

The next page offers general ICD-9 codes from 2007 meant as a reference point to the area of the current ICD-9 manual where needed billing codes will be located.

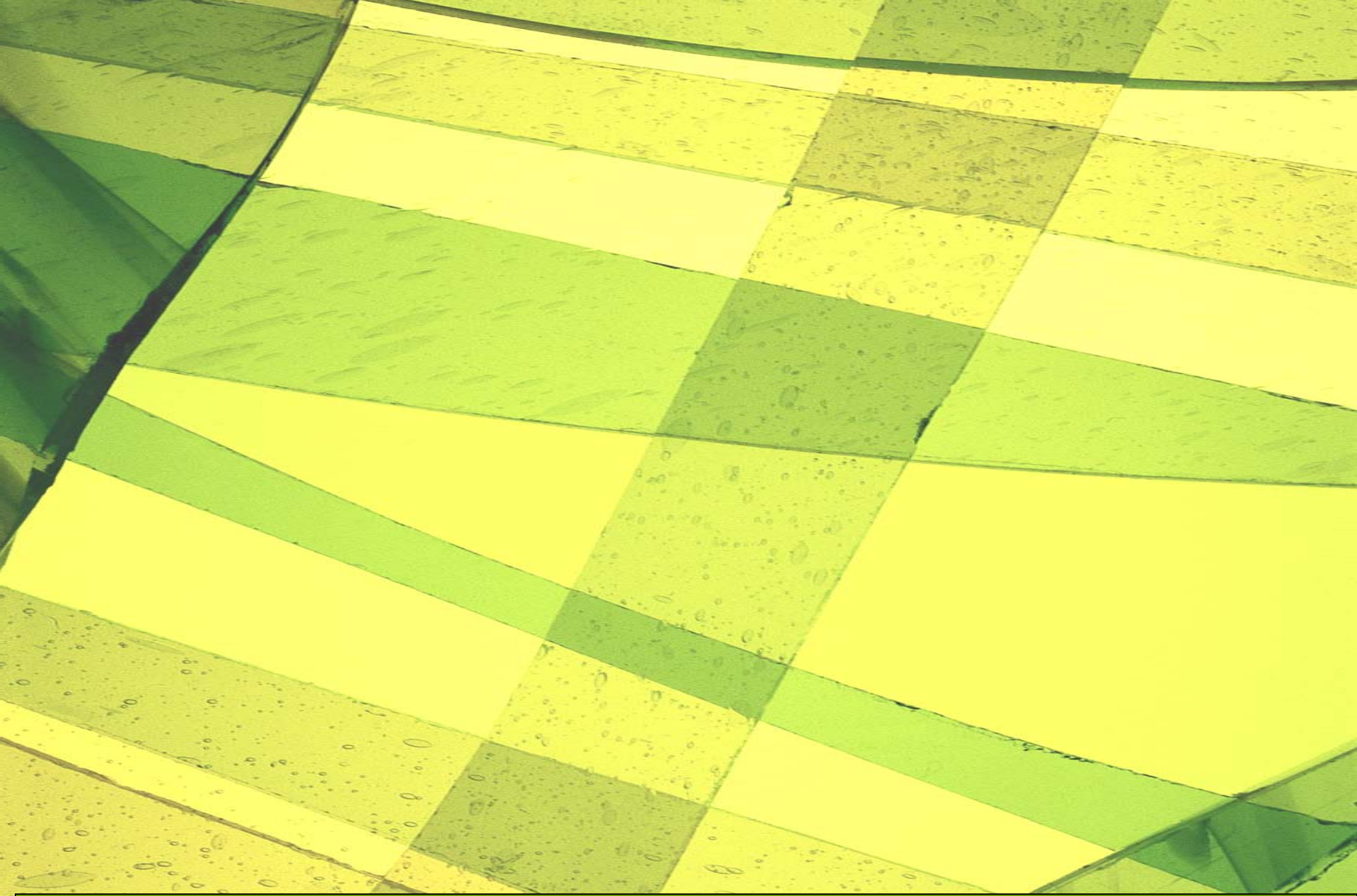
Billing and Coding for Confidential Services

A	Abdominal Pain	789.00
	Abdominal Tenderness	789.60
	Abnormal Findings, w/o Diagnosis (Examination, Laboratory Test)	796.4
	Abnormal Periods (Grossly)	626.9
	Abnormal Urination NEC	788.69
	Abuse Child/Adolescent	995.50
	Abuse Physical	995.54
	Abuse Sexual/Rape	995.53
	Alleged Rape	V71.5
	Amenorrhea/Ovarian	256.8
	Amenorrhea/Primary, Secondary	626.0
	Anal Fissure, Tear	565.0
	Anemia, Iron Deficiency	280.1
	Anemia, Unspecified	285.9
	Annual Pelvic/Pap	V72.31
	Aphthous Ulcer/Stomatitis	528.2
	Alleged Sexual Assault	V71.5
B	Bacterial Vaginosis	616.10
	Balanitis	607.1
	Bartholin Gland, Cyst	616.2
	Bartholin's Gland, Abscess	616.3
	Bloating, Abdominal Pain	787.3
	Boil, Carbuncle	680.9
	Breast Asymmetry	611.9
	Breast Lump/Mass	611.72
	Breast Pain	611.71
	Breast, Problem	611.79
C	Candidal Vulvovaginitis	112.1
	Cellulitis/Abscess	682.9
	Cervicitis, Chlamydial	099.53
	Cervicitis, Gonococcal	098.15
	Cervicitis, Unspecified	616.0
	Chlamydia Urethritis (STD)	099.41
	Condyloma Acuminatum	078.11
	Conjunctivitis, Acute	372.00
	Contact/Exposure to STD	V01.6
	Contraception, Emergency Counseling & Prescription	V25.03
	Contraception, Initiation, Non-Oral (Injection, Device)	V25.02
	Contraception Surveillance	V25.40
	Contraceptive Counseling/Family	V25.09
	Contraceptive Initiation, Oral	V25.01
	Contraceptive Maintenance, Oral	V25.41
	Contraceptive Management NEC (Depo-Provera)	V25.49
	Contraceptive Monitoring, Oral (Includes Repeat Prescription)	V25.41
	Counseling, Health Problems in Family	V61.49
	Counseling, Explanation/Medication	V65.49
	Counseling, HIV	V65.44
	Counseling, Other	V65.40
	Counseling, Parent-Child Conflict	V61.20
	Counseling, Phase of Life Problem	V62.89
C	Counseling, Pregnancy	V26.4
	Counseling, STD Prevention	V65.45
	Counseling, Substance Use/Abuse	V65.42
	Counseling, Victim of Abuse NEC	V62.89
	Crabs, Genital	132.2
	Cramps, Lower Abdominal	729.82
	Cyst, Ovary	620.2
	Cystitis	595.9
D	Delayed Puberty	259.0
	Dermatitis, Atopic	691.8
	Dermatitis, Contact, Unspecified	692.9
	Diabetes Mellitus, w/o Mention of Complication:	
	Type II/Unspecified, Not Stated as Uncontrolled	250.00
	Type II/Unspecified, Uncontrolled	250.02
	Diarrhea	787.91
	Diarrhea/Dysentery/Infections	009.2
	Difficulty Walking	719.7
	Disturbance, Sleep	780.59
	Dizziness	780.4
	DUB	626.8
	Dysmenorrhea	625.3
	Dysuria	788.1
E	Elevated Blood Pressure w/o Hypertension	796.2
	Emergency Contraceptive Counseling & Rx	V25.03
	Enuresis	788.36
	Epididymitis	604.90
	Erythema, First Degree	949.1
	Exam for Alleged Rape	V71.5
	Exanthem (Rash)	782.1
	Excessive Beginning Periods	626.3
	Excessive Bleeding, Menses	626.2
F	Fatigue	780.79
	Folliculitis	704.8
	Follow-up Exam After STD Treatment	V67.59
	Follow-up Exam, Pap Smear	V67.01
	Follow-up Exam/Recheck	V58.89
	Follow-up, Unspecified	V67.9
	Foreign Body, Vagina	939.2
	Foreign Body, Penis	939.3
G	Galactorrhea	611.6
	Gastritis, Acute	535.50
	Gastroenteritis	558.9
	Gastroenteritis, Infection	009.0
	Genital Herpes	054.10
	Genital Pain, Female	625.9
	Genital Pain, Male	608.9

G	Glucose Fasting Test, Impaired	790.21
	Glucose Tolerance Test, Impaired (Oral)	790.22
	Glycosuria	791.5
	Gonococcal Cervicitis	098.15
	Gonorrhea, Acute Urethritis, Vulvovaginitis	098.0
	Gynecological Exam (Pap)	V72.31
	Gynecomastia	611.1
H	Hematuria (Gross)	599.7
	Hemorrhoids	455.6
	Hernia, Inguinal	550.90
	Hepatitis, Unspecified, w/o Coma	070.9
	Hepatitis w/ Infectious Mononucleosis	075 + 573.1
	Herpes, Genital	054.10
	Herpes, Labialis (Simplex)	054.9
	Herpes Zoster/Shingles	053.9
	Herpetic Gingivostomatitis	054.2
	Hidradenitis (Suppurative)	705.83
	Hirsutism	704.1
	HIV Counseling	V65.44
	HIV Infection w/o Sx	V08
	Hives/Urticaria	708.9
	Homeless	V60.0
	Human Papilloma Virus (HPV)	079.4
	Hydrocele	603.9
	Hyperinsulinemia	251.1
	Hypothyroidism	244.9
I	Immunization	V06.9
	Imperforate Hymen	752.42
	Infectious Mononucleosis	075
	Infrequent, Menses	626.1
	Injury, Penis	959.13
	Injury, Vaginal	959.14
	Irregular, Menses, Periods	626.4
	Irritable Bowel Syndrome	564.1
L	Labial Adhesion	623.2
	Laceration, Penis	878.0
	Laceration, Vaginal	878.6
	Lice, Pubic	132.2
	Lymphadenitis, Unspecified	289.3
	Lymphadenopathy	785.6
M	Malnutrition (Calories), Unspecified	263.9
	Mass, Breast	611.72
	Mass, Scrotum	608.89
	Mastalgia	611.71
	Medical Examination for Camp/School	V70.3
	Menorrhagia (Primary)	626.2
M	Menometrorrhagia	626.2
	Menstruation, Normal Cycle	626.5
	Menstruation, Pubertal	626.3
	Metrorrhagia	626.6
	Mittelschmerz	625.2
	Molluscum Contagiosum	078.0
	Moniliasis, Vulvovaginitis	112.1
	Mononucleosis, Infectious	075
N	Nausea (Alone)	787.02
	Nausea and Vomiting	787.01
O	Obesity	278.00
	Overweight	278.02
	Oligomenorrhea	626.1
	Ovarian Cyst	620.2
P	Pain, Abdominal	789.00
	Pain, Breast	611.71
	Pain, Pelvic (Female)	625.9
	Pap Smear, Abnormal	795.09
	Pap Smear, Follow-up Abnormal	V72.32
	Pap Smear, Follow-up	V67.01
	PCO (Polycystic Ovary)	256.4
	Pediculosis, Body	132.1
	Pediculosis, Genital	132.2
	Pelvic Inflammatory Disease	614.9
	Pharyngitis, Acute Sore Throat	462
	Phobia, Isolated or Specific	300.29
	Physical Abuse, Hx of Child Physical/ Sexual Abuse/Rape	V15.41
	PMS	625.4
	Polydipsia/Excess Thirst	783.5
	Post Traumatic Stress Disorder	309.81
	Pregnancy (Condition or Positive Test)	V22.2
	Pregnancy, Counseling	V26.4
	Pregnancy Exam or Test (Test Results Pending)	V72.40
	Pregnancy Exam or Test, Negative Result	V72.41
	Pregnant	V22.2
	Premenstrual Tension Syndrome	625.4
	Prescription Refill, Non-contraceptive	V68.1
	Proteinuria	791.0
	Proteinuria, Postural	593.6
	Pruritus, Genital Organs	698.1
	Puberty	V21.1
	Puberty, Delayed	259.0
	Puberty, Precocious	259.1
	Pyelonephritis, Acute	590.10
R	Rape	995.53 + E960.1
	Rape, Alleged	V71.5
	Rash	782.1

S	Scabies	133.0
	Screen for:	
	Chlamydia & Viral Disease	V73.88
	Thyroid	V77.0
	Sebaceous Skin Cyst	706.2
	Scrotal/Testicular Mass	608.89
	Short Stature	783.43
	Skin Infection, Unspecified	686.9
	Somatization Disorder	300.81
	Sport/Job/Camp Physical	V70.3
	Sleep Disturbance	780.59
	STD, Contact	V01.6
	STD, Counseling	V65.45
	STD, Follow-up Exam	V67.59
	STD, Screening	V75.9
	STD, Unspecified	099.9
	Stress, Acute	308.3
	Syphilis, Genital (Primary)	091.0
T	Testicle Torsion	608.2
	Throat Pain	784.1
	Thyroid Enlargement	240.9
	Tonsillitis, Acute	463
	Trichomonal, Vulvovaginitis	131.01
U	Underweight	783.22
	Urethral Discharge	788.7
	Urethritis, Gonococcal	098.0
	Urethritis, STD	099.40
	Urethritis, Non-STD	598.8
	Urinary Complaints, Sx	788.9
	Urinary Frequency	788.41
	Urinary Urgency	788.63
	UTI	599.0
V	Vaginal Bleeding	623.8
	Vaginal Discharge	623.5
	Varicocele	456.4
	Vertigo/Dizziness	780.4
	Viral Exanthem	057.9
	Viral Infection, Unspecified	079.99
	Vomiting (Alone)	787.03
	Vomiting, Persistent	536.2
	Vulvovaginitis	616.10
	Vulvovaginitis, Candidal	112.1
	Vulvovaginitis, Trichomoniasis	131.01
W	Warts, Genital	078.19
	Warts, Unspecified	078.10
	Weight Gain/Overweight	783.1
	Weight Check	783.3
	Weight Loss	783.21
	Well Child (0-17)	V20.2
	Well Child (18+)	V70.0
	Worried Well (Could Not Find Problem)	V65.5
		(See also V71.x)

The previous pages offer general ICD-9 codes from 2007 meant as reference points to the area of the current ICD-9 manual where needed billing codes will be located.



Taking A Sexual History

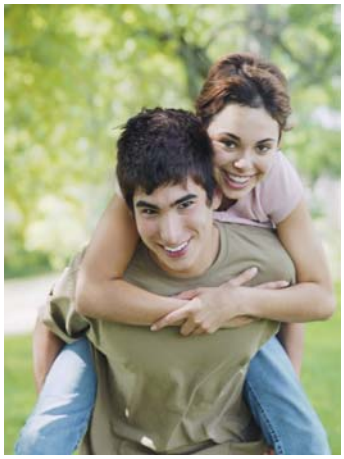
Taking a Sexual History

The following section will take you through:

- The important components of a Sexual History
- Examples for taking a Sexual History
- The Sexual History Questionnaire

Taking a Sexual History

The Importance of a Sexual History



Taking a sexual history is a necessary component of a patient's exam. It provides important information to the provider in order to:

- identify if the patient is at risk for Chlamydia (or other STDs, including HIV)
- prevent or treat possible infection among the patient's partner(s)
- educate the patient on reducing their risk
- to identify appropriate anatomical sites for certain STD tests

A sexual history needs to be taken during a patient's initial visit, during routine preventive exams, and when you see signs of sexually transmitted diseases (STDs).

Introduction to a Sexual History

Some patients may not be open or comfortable with talking about their sexual behaviors, partners, practices, or history. By letting them know that a sexually history is an important part of a regular medical exam or physical history; you may be able to put the patient at ease. It is also important to inform the patient that their information is completely confidential and will not be shared with anyone but their health care provider. Your method for taking a sexual history will need to be modified in order to be appropriate for each patient based on their gender, age, and culture. Using open-ended questions will help guide the discussion.

Introduction Examples

- "I am going to ask you some questions about your sexual health and sexual practices. I understand that these questions are very personal, but they are important for your overall health and will not be shared outside of this room."
- "I am going to ask you some questions that I ask to all of my patients. These questions are just as important as those concerning your physical or mental health. This information will be kept in complete confidence, just like the rest of our visits. Do you have any questions or concerns before we get started?"
- "Sexual health can impact the overall quality of life as greatly as the other areas of your health. Your sexual health can range from issues that are irritating to life threatening. I want to ask you some questions about your sexual history and practices so that we can make sure your sexual health is in check."

****If your patient seems shy or unwilling to be open about their sexual history, refer to the questionnaire at the end of this section to help you get started.**

The 5 P's of a Sexual History

I. Practices

This area is addressed to determine which types of sexual contact the patient is having or has had in the past year. By determining which sexual practices the patient participates in, you will be able to assess the patient's risk as well as determine which testing is necessary and which anatomical sites specimens should be collected from. If risks are identified, strategies to reduce those risks should be developed with the patient. Other risks may include having sex while under the influence of alcohol or drugs, having unwanted sex, using IV drugs (HIV/Hepatitis screening), and the behaviors of the patient's partner(s).

II. Partners

In this section it is important to discuss the number and gender of your patient's partners while remembering not to make assumptions about sexual orientation. If the patient has only had one partner within the last year, determine the length of the relationship.

III. Protection from STDs

The purpose of this component is to assess the patient's use of protection as well as what kind, how often it's used, if it's used correctly, and under what circumstances it's used. It's also important during this discussion to ask the patient if they have any questions about protection or need additional information about methods of protection.

IV. Past history of STDs

It is important to determine whether the patient has had a previous history of STDs because it may place them at a greater risk now. Ask the patient if they have ever been tested for Chlamydia or any other STDs. If the patient has been tested before and has had a previous STD diagnosis, find out when it was diagnosed and how they were treated. Also, ask if there have been any recurring symptoms or diagnoses. Remember to discuss the patient's current or previous partner(s) and whether they have ever been diagnosed and treated for an STD. This will help assess any additional risk the patient might have.

V. Prevention of Pregnancy

Based on what information you've gathered thus far in the sexual history, you may be able to determine if the patient is at risk of becoming pregnant or fathering a child. Ask the patient if a pregnancy is currently desired between the patient and their partner. If it is not desired, ask if the patient is concerned about getting pregnant or getting a partner pregnant. Discuss with the patient their methods of contraception or birth control. Provide any needed information on contraceptive methods.

Completing the History

Thank the patient for being honest and open about their sexual history and praise them for any protective practices. For patients at risk of Chlamydia or other STDs, encourage them to get tested and explain prevention methods to reduce or avoid risk. Express your concern. It may help the patient accept any counseling referrals they are given.

The 6th P: Parent Involvement

A parent's involvement in their child's health is crucial to their child's well-being. However, their involvement may change during every year of their child's adolescent growth to adulthood. The following steps can help you as a provider to transition from parent accompaniment to a confidential setting for the adolescent while still encouraging the parent's involvement and discussion with their child.

1

- Send a letter to the adolescent patients' parents on the youth's 11th or 12th birthday explaining the policy to help families come prepared for the adolescent and provider to spend time alone. ***An example is on the next page.***
- Explain the goals and plan for the visit
- Explain any policies regarding adolescent visits
- Validate the parental role in their child's health and well-being
- Elicit any specific questions or concerns from the parent
- Direct questions and discussion to the adolescent while attending to and validating parental input

2

- Invite the parent(s) to have a seat in the waiting area, assuring them that you will call them prior to closing the visit

3

- Once the parent is out of the room, revisit issues of consent and confidentiality with the adolescent, including situations when confidentiality has to be breached (suicidality, abuse, positive HIV test, etc.)
- Revisit areas of parental concern with the adolescent and obtain the adolescent's perspective
- Conduct the psycho-social interview and physical exam (ascertain whether the adolescent desires parent's presence during the physical exam and accommodate the adolescent's preference)

4

- Clarify what information from the psycho-social interview and physical exam the adolescent is comfortable sharing with the parent
- Ask the patient if they need help sharing sexuality information with their parent: what type of help, what the adolescent expects the parent's reactions to be, and how can you as a provider help that go smoothly
- Invite the parent back to close the visit with both parent and adolescent

Remember that even when the chief complaint is acne or an earache, there may be underlying issues which will only surface when the patient is directly asked.

Place this "HAPPY BIRTHDAY LETTER" on your letterhead to send to patients and their parents on the adolescent's 11th or 12th birthday.

Date

Dear Parent or Guardian,

Welcome to adolescent services with {your practice's name}. Now that your son or daughter is a teenager, there are some things I would like to share with you that are important to providing the best medical care. Your child's body is changing and so are his or her feelings. There are many health risks during the teenage years that we try to prevent, such as accidents, violence, unprotected sex, alcohol and drug use, and stress.

Some areas of teen health that we may talk about during appointments are:

- Diet, exercise, and body image
- Fighting, danger, and violence
- Sexuality and sexual behavior
- Safety and driving
- Smoking, drugs, and alcohol
- Working/jobs
- Depression and stress
- Peer pressure and school
- Dating and relationships
- Family life

It is good for parents to stay close to their children. It is also important for you to allow them some time alone to talk about their health and changes in their bodies and lives. This will help your teenager make good decisions. I encourage teenagers to share information about their health with their parents or guardians. However, there will be some things that your teenager would rather talk about with a doctor, nurse, or counselor. Iowa law allows teenagers to receive some health care services on their own. Health care providers have to keep those services confidential. "Confidential" means I will only share this information if a teenager says it is alright. I will also share this information if someone is in danger.

I ask that you support these rules and help your teen learn to care for their own health needs. I look forward to providing ongoing medical care for your child. I will be happy to talk to you about the questions or concerns you may have about this letter and your child's health.

Sincerely,

Using the Questionnaire

The following questionnaire can be used by the provider as a guide, or given to the patient to take in order to find information regarding the patient's sexual history. The questionnaire should be used as a "kick start" to taking the sexual history.

The form does not cover all aspects of a sexual history for every patient. If the patient takes the questionnaire, it should then be discussed with the provider to go more in depth and give the patient the testing and care that they need.

When working with adolescents it's important to stay away from medical terms and try to use language similar to their literacy level. If you're having problems understanding them or feel that your adolescent patients do not fully understand you, you can visit www.urbandictionary.com to help you find slang or other words used for things such as sexual intercourse, partners, contraceptives, anus, vagina, penis, protection, condoms, etc.

Other Tools

If you would like to assess other possible risks of your patient's health than just a sexual history, the following websites have some of these resources.

The Youth Risk Behavior Surveillance System (18 and under)
http://www.cdc.gov/HealthyYouth/yrbs/index.htm

The Behavioral Risk Factor Surveillance System (Adults, over 18)
http://www.cdc.gov/brfss/

Sexual History Questionnaire

The following are questions about your sexual health. Your information will not be shared with anyone except your health care provider. Honest answers will help your provider to offer the best care possible and work with you to help you be healthy.

1. What kinds of sex have you had in the last 3 months?
   _____Vaginal Sex (penis in vagina) _____Oral Sex (mouth on penis, vagina, anus)
   _____Anal Sex (penis in the anus) _____I am not sexually active

2. Which kinds of sex have you had ever?
   _____Vaginal Sex (penis in vagina) _____Oral Sex (mouth on penis, vagina, anus)
   _____Anal Sex (penis in the anus) _____I have never been sexually active

3. In the last year, have you had more than one sex partner? (Sex partners are anyone you've had sex with – even if it was just once.)
   _____Yes _____No, I've had one partner for the last year _____No, I haven't had any partners

4. In the past 6 months, how many sex partners have you had?
   _____

5. Are your sex partners……?
   _____Males only _____Both Males & Females
   _____Females only _____No sex partners

   If you are sexually active or have been sexually active, please answer the following questions.

6. Do you and your sex partner(s) use condoms?
   _____Yes _____No

7. How often do you and your sex partner(s) use condoms?
   _____Always _____Sometimes _____Never

8. If sometimes, in what situations do you use condoms?
   _____

9. Have you ever been tested for STDs or HIV?
   _____Yes _____No

10. Has any of your sex partners ever had an STD?
    _____Yes _____No _____Don't know

11. If yes, were you also tested for the same STD?
    _____Yes _____No

12. Have you ever had a sexually transmitted disease (STD)?
    _____Yes _____No _____Don't know
    If yes, when?_____

13. Have you had any itching, burning, swelling, bumps, etc in or around your vagina, penis, mouth, anus in the past 6 months?
    _____Yes _____No

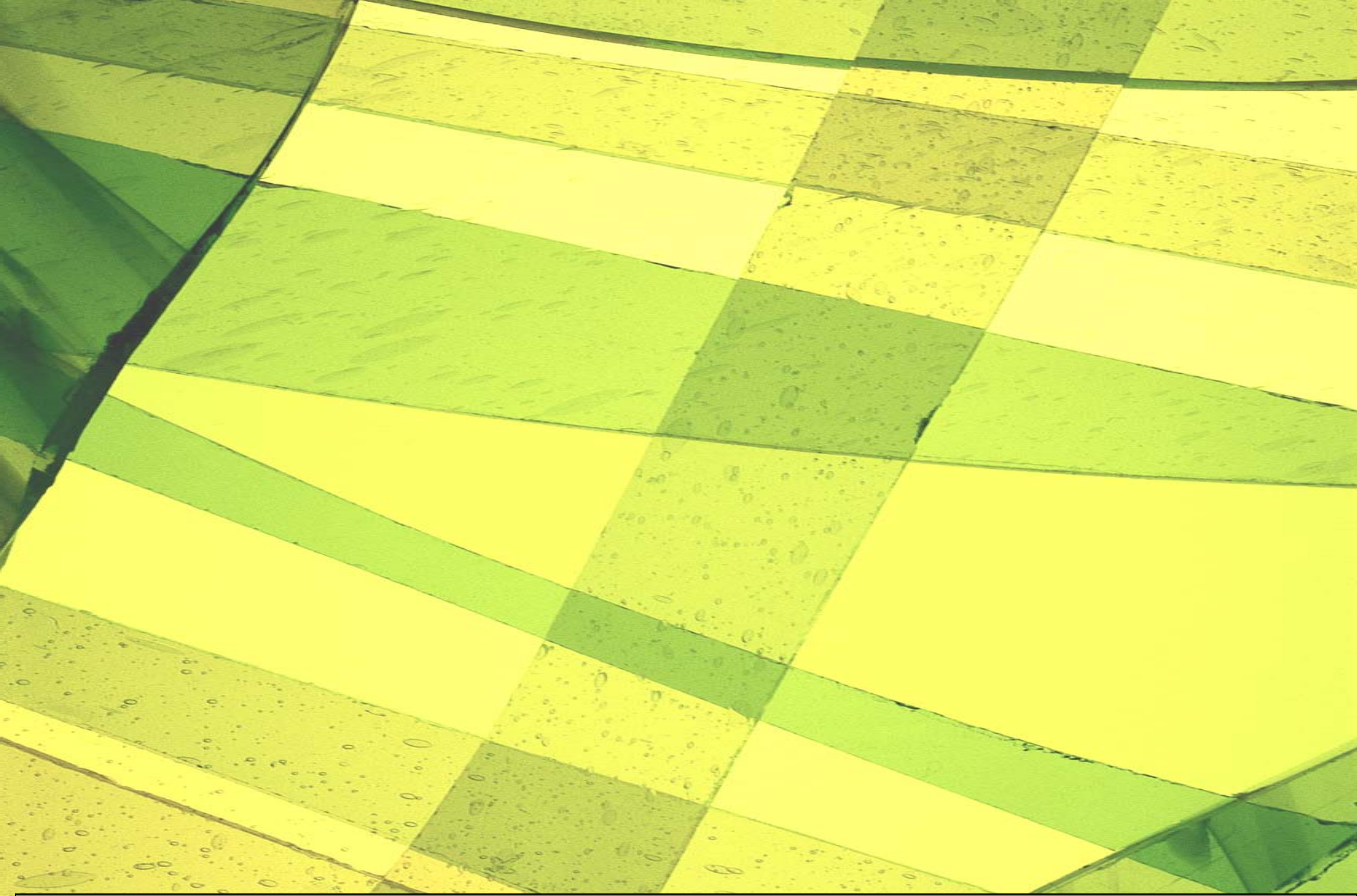
14. Are you concerned about getting pregnant or getting your partner pregnant?
    _____Yes _____No

15. List all of the forms of birth control (condoms, pills, IUD, the patch, etc.) you are using.
    _____

Use this chart to take notes when taking a patient's sexual history.

	Vaginal Sex	Anal Sex	Oral Sex
Are you currently having…?			
Have you ever had…?			
When was the last time you had…?			
How many sex partners have you had in the last 6 months?			
How many sex partners do you currently have?			
Do you have _____ sex with men?			
Do you have _____ sex with women?			
Do you have sex with both men and women?			
Do you use condoms?			
How often do you use condoms?			
When don't you use condoms?			
Have you had any burning, itching, bumps, swelling, belly aches, etc. recently?	**Genitals**	**Anus**	**Mouth**

	Explanation (Yes/No, Specify)
Have you ever been tested for STDs?	
Have you ever had an STD?	
Have any of your sex partners ever had an STD?	
Are you concerned about getting pregnant or getting your partner pregnant?	
Are you using any birth control?	
What kind of birth control are you using?	



CDC Treatment Guidelines

CDC Treatment Guidelines

The following section will take you through:

- CDC Treatment recommendations for Chlamydia
- CDC Treatment recommendations for Gonorrhea
- Presumptive Treatment criteria

CDC Treatment Guidelines

Treating infected patients prevents transmission to sex partners and re-infection of the patient. In addition, treatment of Chlamydia in pregnant women usually prevents transmission of Chlamydia to infants during birth. CDC recommends the following treatment regimens for Chlamydia.

Chlamydia Treatment

*****ALL Regimens, regardless of single dose or 7 day treatment, must be taken in addition to 7 days of Abstinence. If a partner is involved, then the patient must remain abstinent until 7 days after the partner's treatment as well.**

- **Males and Non-pregnant Females**
  - Azithromycin 1g orally in a single dose
  - Doxycycline 100mg orally twice a day for 7 days

- **Alternatives for Males and Non-pregnant Females**
  - Erythromycin base 500mg orally four times a day for 7 days
  - Erythromycin ethylsuccinate 800mg orally four times a day for 7 days
  - Ofloxacin 300mg orally twice a day for 7 days
  - Levofloxacin 500mg orally for 7 days

- **Pregnant Females**
  - Azithromycin 1g orally in a single dose
  - Amoxicillin 500mg orally three times a day for 7 days

- **Alternatives for Pregnant Females**
  - Erythromycin base 500mg orally four times a day for 7-14 days
  - Erythromycin ethylsuccinate 800mg orally four times a day for 7 days
  - Erythromycin ethylsuccinate 400mg orally four times a day for 14 days

- **Children (< 45 kg): Urogenital, rectal**
  - Erythromycin base 50 mg/kg/day orally (4 divided doses) daily for 14 days
  - Ethylsuccinate 50 mg/kg/day orally (4 divided doses) daily for 14 days

- **Neonates: Opthalmia neonatorum, pneumonia**
  - Erythromycin base 50 mg/kg/day orally (4 divided doses) daily for 14 days
  - Erythromycin 50 mg/kg/day orally (4 divided doses) daily for 14 days

Counsel patients to abstain during treatment, use barriers and contraception for prevention, and to re-test in 3 to 4 months.

For more information on treatment guidelines, please visit www.cdc.gov/std/treatment or see the quick reference guide at the end of this section.

Gonorrhea Treatment

Patients infected with Gonorrhea frequently are co-infected with Chlamydia. This finding has led to the recommendation that patients treated for gonococcal infection also be treated routinely with a regimen that is effective against uncomplicated genital Chlamydia infection. Because of the high sensitivity of NAATs for Chlamydia infection, patients with a negative Chlamydia NAAT result at the time of treatment for Gonorrhea do not need to be treated for Chlamydia as well. However, if Chlamydia test results are not available or if a non-NAAT was negative for Chlamydia, patients should be treated for both Gonorrhea and Chlamydia.

*****ALL Regimens, regardless of single dose or 7 day treatment, must be taken in addition to 7 days of Abstinence. If a partner is involved, then the patient must remain abstinent until 7 days after the partner's treatment as well.**

- **Uncomplicated Gonococcal Infections of the Cervix, Urethra, and Rectum**
  - Ceftriaxone 125mg IM in a single dose
  - Cefixime 400mg orally in a single dose
  - **Treatment for Chlamydia if Chlamydia cannot be ruled out**

- **Alternatives for Cervix, Urethra, and Rectum**
  - Single-dose cephalosporin regimens
  - Spectinomycin 2g in a single IM dose (not available in U.S.)
  - **Treatment for Chlamydia if Chlamydia cannot be ruled out**

- **Men who have sex with Men (MSM) or Heterosexuals with a History of Recent Travel**
  - Ceftriaxone 125mg IM in a single dose
  - Cefixime 400mg orally in a single dose
  - **Treatment for Chlamydia if Chlamydia cannot be ruled out**

- **Gonococcal Infection of the Pharynx**
  - Ceftriaxone 125mg IM in a single dose
  - **Treatment for Chlamydia if Chlamydia cannot be ruled out**

- **Conjunctiva**
  - Cefriaxone 1g IM once plus lavage the infected eye with saline solution once
  - **Treatment for Chlamydia if Chlamydia cannot be ruled out**

- **Children (≤ 45 KG)**
  - Ceftriaxone 125mg IM once
  - **Treatment for Chlamydia if Chlamydia cannot be ruled out**

- **Pregnant Women**
  - Ceftriaxone 125mg IM once
  - Cefixime 400mg orally in a single dose
  - **Treatment for Chlamydia if Chlamydia cannot be ruled out**

Counsel patients to abstain from sex during treatment, use barriers and contraception as preventative measures and to re-test in 3 to 4 months.

Presumptive Treatment Criteria

Presumptive treatment occurs before test results are available when a patient presents one or more complaints. Treatment may occur without actually testing the client. The following are criteria for presumptive diagnosis and treatment of Chlamydia:

Males

- History of urethral discharge
- History and/or exam consistent with urethritis, epididymitis, or non-gonococcal urethritis
- History of sexual partner with Chlamydia infection
- History of sexual partner with gonococcal infection
- Symptomatic partner
- History of partner with mucopurulent cervicitis or PID
- Rape victim

Females

- Physical exam consistent with mucopurulent cervicitis, friable cervix, or positive whiff test
- Signs and symptoms of PID
- History of sexual partner with Chlamydia infection
- History of sexual partner with gonococcal infection
- Symptomatic partner
- History of partner with urethritis, epididymitis, or non-gonococcal urethritis
- Rape victim

For more information on treatment guidelines, please visit
www.cdc.gov/std/treatment

The next page contains a summary of the 2006 CDC STD Treatment Guidelines.

SUMMARY OF THE 2006 CDC SEXUALLY TRANSMITTED DISEASES (STD) TREATMENT GUIDELINES
ST. LOUIS STD/HIV PREVENTION TRAINING CENTER

These guidelines for the treatment of STDs reflect the recommendations of the **2006 CDC STD Treatment Guidelines**. These are outlines for quick reference that focus on STDs encountered in an outpatient setting and are not an exhaustive list of effective treatments. Please refer to the complete document of the CDC for more information or call the STD Program. These guidelines are to be used for clinical guidance and are not to be construed as standards or inflexible rules. Clinical and epidemiological services are available through your State STD Program and staff is available to assist providers with confidential notification of sexual partners of patients infected with STDs and HIV.

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVES
SYPHILIS (see 2006 CDC guidelines for follow-up recommendations and management of congenital syphilis)		
PRIMARY, SECONDARY OR EARLY LATENT (< 1 YEAR) **Adults**	• Benzathine penicillin G 2.4 million units IM in a single dose	**(For penicillin allergic non-pregnant adult patients)** Doxycycline 100 mg orally 2 times a day for 14 days ***OR*** Ceftriaxone 1 g daily IV or IM for 8-10 days ***OR*** Azithromycin 2 g orally once[1]
Children	• Benzathine penicillin G 50,000 units/kg IM, up to the adult dose of 2.4 million units, in a single dose	
LATE LATENT (> 1 YEAR) OR LATENT OF UNKNOWN DURATION **Adults**	• Benzathine penicillin G 2.4 million units IM **for 3 doses**, 1 week apart (total 7.2 million units)	• Doxycycline 100 mg orally 2 times a day for 28 days **for adults only**
Children	• Benzathine penicillin G 50,000 units/kg IM up to the adult dose of 2.4 million units, administered as three doses at 1 week intervals (total 150,000 units up to the adult total dose of 7.2 million units)	
NEUROSYPHILIS	• Aqueous crystalline penicillin G 18 - 24 million units per day, administered as 3-4 million units IV every 4 hours or continuous infusion, for 10-14 days	• Procaine penicillin 2.4 million units IM once daily **plus** probenecid 500 mg orally 4 times a day, both for 10-14 days
HIV INFECTION	• **For primary, 2nd and early latent syphilis:** Treat as above. Some specialists recommend three doses. • **For late latent syphilis or latent syphilis of unknown duration:** Perform CSF examination before treatment	• The use of any alternative therapy in HIV infected persons has not been well studied; therefore the use of doxycycline, ceftriaxone and azithromycin must be undertaken with caution.
PREGNANCY	**Penicillin is the only recommended treatment for syphilis during pregnancy. Women who are allergic should be desensitized and then treated with penicillin. Dosages are the same as in non-pregnant patients for each stage of syphilis.[2]**	
GONOCOCCAL INFECTIONS : Treat also for chlamydial infection if not ruled out by a sensitive test (nucleic acid amplification test)		
ADULTS **CERVIX, URETHRA, RECTUM**	• Ceftriaxone 125 mg IM in a single dose ***OR*** • Cefixime 400 mg orally in a single dose ***PLUS*** • **Treatment for Chlamydia if Chlamydia is not ruled out**	• Spectinomycin[5] 2 g IM in a single dose ***OR*** • Single-dose cephalosporins regimens ***OR*** **See 2006 CDC guidelines for discussion of alternative regimens**
PHARYNX	• Ceftriaxone 125 mg IM in a single dose ***PLUS*** • **Treatment for Chlamydia if Chlamydia is not ruled out**	
MEN WHO HAVE SEX WITH MEN OR HETEROSEXUALS WITH A HISTORY OF RECENT TRAVEL **CERVIX, URETHRA, RECTUM**	• Ceftriaxone 125 mg IM in a single dose ***OR*** • Cefixime 400 mg orally in a single dose ***PLUS*** • **Treatment for Chlamydia if Chlamydia is not ruled out**	
PHARYNX	• Ceftriaxone 125 mg IM in a single dose ***PLUS*** • **Treatment for Chlamydia if Chlamydia is not ruled out**	
CONJUNCTIVA	• Ceftriaxone 1 g IM once plus lavage the infected eye with saline solution once	
CHILDREN (≤45KG) VAGINA, CERVIX, URETHRA, PHARYNX, RECTUM	• Ceftriaxone 125 mg IM once	• Spectinomycin[5] 40mg/kg IM once (maximum 2 g)
PREGNANCY	• Ceftriaxone 125 mg IM once ***OR*** • Cefixime 400 mg orally in a single dose	• Spectinomycin[5] 2 g IM once
CHLAMYDIAL INFECTIONS		
ADULT	• Azithromycin 1 g orally single dose ***OR*** • Doxycycline 100 mg orally 2 times a day for 7 days	• Erythromycin base 500 mg orally 4 times a day for 7 days ***OR*** • Erythromycin ethylsuccinate 800 mg orally 4 times a day for 7 days ***OR*** • Ofloxacin[3] 300 mg orally 2 times a day for 7 days ***OR*** • Levofloxacin[3] 500 mg orally once a day for 7 days
CHILDREN **< 45 KG** ⟶	• Erythromycin base or ethylsuccinate 50 mg/kg/day orally divided into four doses daily for 14 days[6]	
≥ 45 KG AND < 8 YEARS OF AGE ⟶	• Azithromycin 1 g orally single dose	
≥ 8 YEARS OF AGE ⟶	• Azithromycin 1 g orally single dose ***OR*** • Doxycycline 100 mg orally 2 times a day for 7 days	
PREGNANCY	• Azithromycin 1 g orally single dose ***OR*** • Amoxicillin 500 mg orally 3 times a day for 7 days	• Erythromycin base 500 mg orally 4 times a day for 7 days ***OR*** Erythromycin 250 mg orally 4 times a day for 14 days ***OR*** • Erythromycin ethylsuccinate 800 mg orally 4 times a day for 7 days ***OR*** • Erythromycin ethylsuccinate 400mg 4 times a day for 14D

[1] Some patients who are allergic to penicillin may also be allergic to ceftriaxone. Doxycycline is the preferred treatment. Treatment failures with azithromycin have been reported (MMWR 2004;53:197-8). *T. pallidum* strains resistant to azithromycin have been documented in various geographic areas in the USA (NEJM 2004;351:454-8.). If neither penicillin nor doxycycline can be administered, and azithromycin as a single dose oral dose of 2 g is considered, close follow-up is essential to ensure successful treatment. There are limited clinical studies also for ceftriaxone. Close follow-up of persons receiving any alternative therapies is essential.

[2] Tetracycline/doxycycline contraindicated; erythromycin not recommended because it does not reliably cure an infected fetus; data insufficient to recommend azithromycin or ceftriaxone.

[3] Quinolones are contraindicated in pregnant women. No joint damage attributable to quinolone therapy has been observed in children treated with prolonged ciprofloxacin regimens. Thus children who weigh > 45 kg can be treated with any regimen recommended for adults.

[4] Quinolones should not be used for infections in men who have sex with men or in those with a history of recent foreign travel or partners' travel, infections acquired in California or Hawaii, or infections acquired in other areas with increased quinolone resistant *Neisseria gonorrhoeae*

[5] Unreliable to treat pharyngeal infections. Patients who have suspected or known pharyngeal infection should have a pharyngeal culture 3-5 days after treatment to verify eradication of infection.

[6] The efficacy of treating neonatal chlamydial conjunctivitis and pneumonia is about 80%. A second course of therapy may be required. An association between oral erythromycin and infantile hypertrophic pyloric stenosis (IHPS) has been reported in infants aged less than 6 weeks treated with this drug. Data on other macrolides (azithromycin, clarithromycin) for the treatment of neonatal chlamydial infection are limited. The results of one study involving a limited number of patients suggest that a short course of azithromycin 20 mg/kg/day, 1 dose daily for 3 days may be effective for chlamydial conjunctivitis.

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVES
NONGONOCOCCAL URETHRITIS	• Azithromycin[7] 1 g orally single dose ***OR*** • Doxycycline 100 mg orally 2 times a day x 7 days	• Erythromycin base[8] 500 mg orally 4 times a day for 7 days ***OR*** • Erythromycin ethylsuccinate[8] 800 mg orally 4 times a day for 7 days ***OR*** • Ofloxacin[3] 300 mg orally 2 times a day for 7 days ***OR*** • Levofloxacin[3] 500 mg orally once a day for 7 days
EPIDIDYMITIS[9]	• Ceftriaxone 250 mg IM single dose ***PLUS*** • Doxycycline 100 mg orally 2 times a day for 10 days	• Ofloxacin[4] 300 mg orally twice daily for 10 days ***OR*** levofloxacin[4] 500 mg orally once a day for 10 days
PELVIC INFLAMMATORY DISEASE[10] **(outpatient management)** **These regimens to be used with or without metronidazole 500 mg orally twice a day for 14 days**	**REGIMEN A** Ofloxacin[3,4] 400 mg orally 2 times a day for 14 days ***OR*** Levofloxacin[3,4] 500 mg orally once a day for 14 days **REGIMEN B** Ceftriaxone 250 mg IM once ***OR*** Cefoxitin 2 g IM once plus probenicid 1 g orally once ***OR*** Other third generation cephalosporin ***PLUS*** Doxycycline 100 mg orally 2 times a day for 14 days	
PREGNANCY AND PID	**Patients should be hospitalized and treated with the appropriate recommended parenteral IV treatments (see CDC guidelines)**	
CHANCROID	• Azithromycin 1 g orally single dose ***OR*** • Ceftriaxone 250 mg IM single dose ***OR*** • Ciprofloxacin[3,4] 500 mg orally 2 times a day for 3 days ***OR*** • Erythromycin base 500 mg orally 3 times a day for 7 days (preferred by some experts if HIV co-infection)	
HERPES SIMPLEX VIRUS (for non-pregnant adults).	See CDC 2006 guidelines for the management of herpes in pregnancy and in the neonate	
First clinical episode of genital herpes	• Acyclovir 400 mg orally 3 times a day for 7-10 days ***OR*** 200 mg orally 5 times a day for 7-10 days ***OR*** • Famciclovir 250 mg orally 3 times a day for 7-10 days ***OR*** • Valacyclovir 1 g orally 2 times a day for 7-10 days	
Daily Suppressive therapy	• Acyclovir 400 mg orally 2 times a day ***OR*** • Famciclovir 250 mg orally 2 times a day ***OR*** • Valacyclovir 500 mg orally once a day ***OR*** 1 g orally once a day	
Episodic Recurrent Infection	• Acyclovir 800 mg orally 2 times a day for 5 days ***OR*** 400 mg orally 3 times a day for 5 days ***OR*** 800 mg orally 3 times a day for 2 days ***OR*** • Famciclovir 125 mg orally 2 times a day for 5 days ***OR*** 1000 mg orally 2 times a day for 1 day • Valacyclovir 500 mg orally 2 times a day for 3 days ***OR*** 1 g orally once a day for 5 days	
HIV INFECTION	Higher doses and/or longer therapy recommended. See 2006 CDC guidelines.	
PEDICULOSIS PUBIS[11]	• Permethrin 1% cream rinse applied to affected area and washed off after 10 minutes ***OR*** • Pyrethrins with piperonyl butoxide applied to affected area and washed off after 10 minutes	Malathion 0.5% lotion applied for 8-12 hours and washed off ***OR*** Ivermectin 250 ug/kg repeated in 2 weeks
SCABIES	• Permethrin 5% cream applied to all areas of the body from the neck down and washed off after 8-14 hours ***OR*** • Ivermectin 200ug/kg orally, repeated in 2 weeks	• Lindane[12] 1% 1 oz of lotion or 30 g of cream applied thinly to all areas of the body and thoroughly washed off after 8 hours
BACTERIAL VAGINOSIS (BV)	• Metronidazole[13] 500 mg orally 2 times a day for 7 days ***OR*** • Metronidazole gel 0.75% intravag. once a day for 5 days ***OR*** • Clindamycin cream 2% intravag. at bedtime for 7 days	• Clindamycin 300 mg orally 2 times a day for 7 days ***OR*** • Clindamycin ovules 100 g intravag. at bedtime for 3 days
PREGNANCY AND BV[13]	• Metronidazole[13] 500 mg orally 2 times a day for 7 days ***OR*** • Metronidazole[13] 250 mg orally 3 times a day for 7 days ***OR*** • Clindamycin 300 mg orally 2 times a day for 7 days	
TRICHOMONIASIS	• Metronidazole 2 g orally single dose ***OR*** • Tinidazole[14] 2 g orally single dose	• Metronidazole 500 mg orally 2 times a day for 7 days

GENITAL WARTS

External	Urethral Meatus	Vaginal	Anal	Oral
• **PROVIDER-ADMINISTERED** **Cryotherapy** with liquid nitrogen or cryoprobe. Repeat applications every 1-2 weeks if necessary ***OR*** **Trichloroacetic acid (TCA) or bichloroacetic acid (BCA)** 80% -90%. Apply small amount only to warts. Allow to dry. If excess amount applied, powder with talc, baking soda or liquid soap. Repeat weekly if necessary ***OR*** **Podophyllin resin 10%-25%[14]** in a compound tincture of benzoin. Allow to air dry. Limit application to < 10 cm^2 and to ≤ 0.5 ml. Wash off 1-4 hours after application. Repeat weekly if necessary ***OR*** **Surgical removal** • **PATIENT-APPLIED** **Podofilox 0.5% solution or gel[14]**. Apply 2 times a day for 3 days, followed by 4 days of no therapy. This cycle can be repeated as necessary for up to 4 times. Total wart area should not exceed 10 cm^2 and total volume applied daily not to exceed 0.5 ml. ***OR*** **Imiquimod 5% cream[14]**. Apply once daily at bedtime 3 times a week for up to 16 weeks. Wash treatment area with soap and water 6-10 hours after application.	**Cryotherapy** with liquid nitrogen ***OR*** **Podophyllin 10%-25%[14]** in a compound tincture of benzoin. Treatment area must be dry before contact with normal mucosa. Repeat weekly if necessary.	**Cryotherapy** with liquid nitrogen. Cryoprobe not recommended (risk of perforation and fistula formation) ***OR*** **TCA or BCA 80%-90%.** Apply small amount only to warts. If excess amount applied, powder with talc, baking soda or liquid soap. Repeat weekly if necessary.	**Cryotherapy** with liquid nitrogen ***OR*** **TCA or BCA 80%-90%.** Apply small amount only to warts. If excess amount applied, powder with talc, baking soda or liquid soap. Repeat weekly if necessary. Many persons with anal warts may also have them in the rectal mucosa. Inspect rectal mucosa by digital examination or anoscopy. Warts on the rectal mucosa should be managed in consultation with a specialist.	**Cryotherapy** with liquid nitrogen ***OR*** **Surgical removal**

[7] Infections with *M. genitalium* may respond better to azithromycin.

[8] If this dose cannot be tolerated, then erythromycin base 250 mg orally or erythromycin ethylsuccinate 400 mg orally 4 times a day for 14 days can be used.

[9] The recommended regimen of ceftriaxone and doxycycline is for epididymitis most likely caused by GC or CT infection. The alternative regimen of ofloxacin or levofloxacin is recommended if the epididymitis is most likely caused by enteric organisms, or for patients allergic to cephalosporins and/or tetracycline.

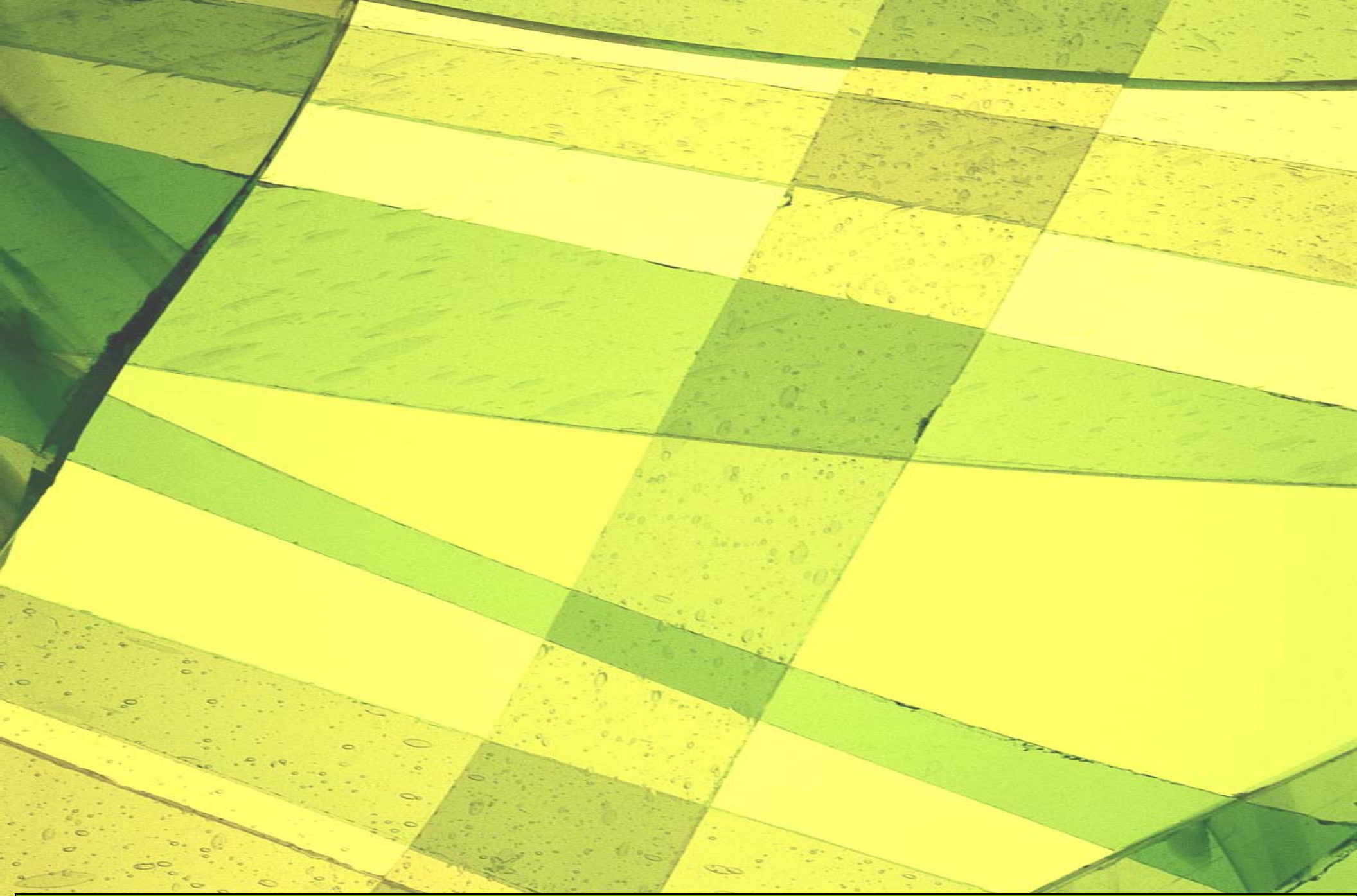
[10] Metronidazole will also treat bacterial vaginosis, frequently associated with PID. Whether the management of immunodeficient HIV-infected women with PID requires more aggressive intervention has not been determined.

[11] Lindane no longer recommended because of toxicity and is contraindicated in pregnancy. Ivermectin not recommended for pregnant and lactating women or for children who weigh < 15 kg. Pregnant or lactating women should be treated with either permethrin or pyrethrins with piperonyl butoxide

[12] Lindane no longer recommended as first line therapy because of toxicity. Lindane not to be used immediately after a bath, in persons with extensive dermatitis and women who are pregnant or lactating, or children aged < 2 years.

[13] Multiple studies and meta-analyses have not demonstrated a consistent association between metronidazole use during pregnancy and teratogenic or mutagenic effects in newborns. Screening for, and oral treatment of, BV in pregnant women at high risk for premature delivery is recommended by some experts and should occur at the first prenatal visit. Intravaginal clindamycin treatment for low risk women should be used only during the first half of pregnancy.

[14] Safety during pregnancy **not** established.



Patient Education & Partner Management

Patient Education and Partner Management

The following section will take you through:

- Education methods and tools for patients
- Partner Management
- Expedited Partner Therapy
- Partner Notification Referrals
- Iowa Disease Prevention Specialists

Patient Education

It is important to educate your sexually active patients on Chlamydia. They should be educated on what Chlamydia is and how its spread, the signs and symptoms of Chlamydia, how to find out if they have the disease, how serious it is, and how to avoid contracting Chlamydia.

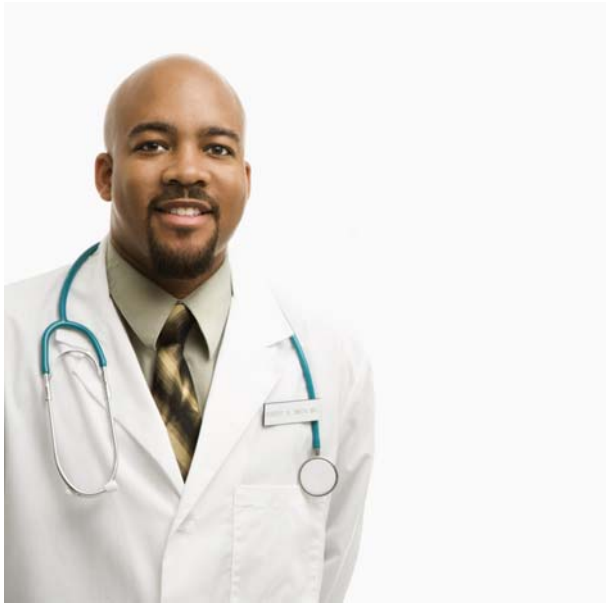
Patients might also ask about abstinence or condom negotiation with a partner. Be prepared to give your patients ideas of the types of phrases that can be used to communicate to partners. The examples below can be used to negotiate abstinence or condom use:

Tell your patients:

"Sometimes you might feel pressured into doing something that you aren't comfortable with or ready for, like having sex (or, having sex without a condom). There are ways to talk about it and be heard. Remember, it's your body"

- I like you too, but I'm not ready…
- I'm glad you asked first, but…
- I care about you too, but no…
- I'm going to…
- I believe in…
- I've decided to…

Help your patients remember that they don't HAVE to give a reason and they don't need to argue. Remind them that, if it isn't comfortable, they should respect their own feelings.



The following fact sheets from CDC and the Iowa Department of Public Health can be used for your information or for you to pass out to your patients.

CDC Fact Sheet

Chlamydia

What is chlamydia?

Chlamydia is a common sexually transmitted disease (STD) caused by the bacterium, *Chlamydia trachomatis*, which can damage a woman's reproductive organs. Even though symptoms of chlamydia are usually mild or absent, serious complications that cause irreversible damage, including infertility, can occur "silently" before a woman ever recognizes a problem. Chlamydia also can cause discharge from the penis of an infected man.

How common is chlamydia?

Chlamydia is the most frequently reported bacterial sexually transmitted disease in the United States. In 2006, 1,030,911 chlamydial infections were reported to CDC from 50 states and the District of Columbia. Under-reporting is substantial because most people with chlamydia are not aware of their infections and do not seek testing. Also, testing is often not done if patients are treated for their symptoms. An estimated 2,291,000 non-institutionalized U.S. civilians ages 14-39 are infected with chlamydia based on the U.S. National Health and Nutrition Examination Survey. Women are frequently re-infected if their sex partners are not treated.

How do people get chlamydia?

Chlamydia can be transmitted during vaginal, anal, or oral sex. Chlamydia can also be passed from an infected mother to her baby during vaginal childbirth.

Any sexually active person can be infected with chlamydia. The greater the number of sex partners, the greater the risk of infection. Because the cervix (opening to the uterus) of teenage girls and young women is not fully matured and is probably more susceptible to infection, they are at particularly high risk for infection if sexually active. Since chlamydia can be transmitted by oral or anal sex, men who have sex with men are also at risk for chlamydial infection.

What are the symptoms of chlamydia?

Chlamydia is known as a "silent" disease because about three quarters of infected women and about half of infected men have no symptoms. If symptoms do occur, they usually appear within 1 to 3 weeks after exposure.

In women, the bacteria initially infect the cervix and the urethra (urine canal). Women who have symptoms might have an abnormal vaginal discharge or a burning sensation when urinating. When the infection spreads from the cervix to the fallopian tubes (tubes that carry fertilized eggs from the ovaries to the uterus), some women still have no signs or symptoms; others have lower abdominal pain, low back pain, nausea, fever, pain during intercourse, or bleeding between menstrual periods. Chlamydial infection of the cervix can spread to the rectum.

Men with signs or symptoms might have a discharge from their penis or a burning sensation when urinating. Men might also have burning and itching around the opening of the penis. Pain and swelling in the testicles are uncommon.

Men or women who have receptive anal intercourse may acquire chlamydial infection in the rectum, which can cause rectal pain, discharge, or bleeding. Chlamydia can also be found in the throats of women and men having oral sex with an infected partner.

What complications can result from untreated chlamydia?

If untreated, chlamydial infections can progress to serious reproductive and other health problems with both short-term and long-term consequences. Like the disease itself, the damage that chlamydia causes is often "silent."

In women, untreated infection can spread into the uterus or fallopian tubes and cause pelvic inflammatory disease (PID). This happens in up to 40 percent of women with untreated chlamydia. PID can cause permanent damage to the fallopian tubes, uterus, and surrounding tissues. The damage can lead to chronic pelvic pain, infertility, and potentially fatal ectopic pregnancy (pregnancy outside the uterus). Women infected with chlamydia are up to five times more likely to become infected with HIV, if exposed.

To help prevent the serious consequences of chlamydia, screening at least annually for chlamydia is recommended for all sexually active women age 25 years and younger. An annual screening test also is recommended for older women with risk factors for chlamydia (a new sex partner or multiple sex partners). All pregnant women should have a screening test for chlamydia.

Complications among men are rare. Infection sometimes spreads to the epididymis (the tube that carries sperm from the testis), causing pain, fever, and, rarely, sterility.

Rarely, genital chlamydial infection can cause arthritis that can be accompanied by skin lesions and inflammation of the eye and urethra (Reiter's syndrome).

How does chlamydia affect a pregnant woman and her baby?

In pregnant women, there is some evidence that untreated chlamydial infections can lead to premature delivery. Babies who are born to infected mothers can get chlamydial infections in their eyes and respiratory tracts. Chlamydia is a leading cause of early infant pneumonia and conjunctivitis (pink eye) in newborns.

How is chlamydia diagnosed?

There are laboratory tests to diagnose chlamydia. Some can be performed on urine, other tests require that a specimen be collected from a site such as the penis or cervix.

What is the treatment for chlamydia?

Chlamydia can be easily treated and cured with antibiotics. A single dose of azithromycin or a week of doxycycline (twice daily) are the most commonly used treatments. HIV-positive persons with chlamydia should receive the same treatment as those who are HIV negative.

All sex partners should be evaluated, tested, and treated. Persons with chlamydia should abstain from sexual intercourse until they and their sex partners have completed treatment, otherwise re-infection is possible.

Women whose sex partners have not been appropriately treated are at high risk for re-infection. Having multiple infections increases a woman's risk of serious reproductive health complications, including infertility. Retesting should be encouraged for women three to four months after treatment. This is especially true if a woman does not know if her sex partner received treatment.

How can chlamydia be prevented?

The surest way to avoid transmission of STDs is to abstain from sexual contact, or to be in a long-term mutually monogamous relationship with a partner who has been tested and is known to be uninfected.

Latex male condoms, when used consistently and correctly, can reduce the risk of transmission of chlamydia.

CDC recommends yearly chlamydia testing of all sexually active women age 25 or younger, older women with risk factors for chlamydial infections (those who have a new sex partner or multiple sex partners), and all pregnant women. An appropriate sexual risk assessment by a health care provider should always be conducted and may indicate more frequent screening for some women.

Any genital symptoms such as an unusual sore, discharge with odor, burning during urination, or bleeding between menstrual cycles could mean an STD infection. If a woman has any of these symptoms, she should stop having sex and consult a health care provider immediately. Treating STDs early can prevent PID. Women who are told they have an STD and are treated for it should notify all of their recent sex partners (sex partners within the preceding 60 days) so they can see a health care provider and be evaluated for STDs. Sexual activity should not resume until all sex partners have been examined and, if necessary, treated.

FOR MORE INFORMATION:

Division of STD Prevention (DSTDP)

Centers for Disease Control and Prevention

http://www.cdc.gov/std/

CDC-INFO Contact Center

1-800-CDC-INFO (1-800-232-4636)

Email: cdcinfo@cdc.gov

American Social Health Association (ASHA)

1-800-783-9877

www.ashastd.org

CHLAMYDIA FACTS

(Caused by Chlamydia trachomatis, a bacteria)

SIGNS AND SYMPTOMS

- Usually begin 7-21 days after exposure
- Most people have no symptoms

Chlamydia Symptoms for Women:

- Most women have no symptoms
- Abnormal vaginal bleeding, discharge or itching
- Burning or pain during urination
- More pain than usual during periods
- Cramps and pain in lower abdomen
- Anal discomfort, itching or discharge

Chlamydia Symptoms for Men:

- Most men have no symptoms
- Watery or thin white discharge from penis
- Burning or pain during urination or bowel movement
- Anal discomfort, itching or discharge

TRANSMISSION

Chlamydia is spread by:

- Vaginal sex
- Oral sex
- Anal sex
- Infected mother to unborn child during childbirth

COMPLICATIONS

If left untreated, Chlamydia can:

- Lead to pelvic inflammatory disease (PID) in women
- Lead to epididymitis (swollen testicles) in men
- Lead to ectopic (tubal) pregnancy
- Lead to infertility in men and women
- Spread to other sex partners

Chlamydia and pregnancy:

- Can be passed to newborn during childbirth and cause serious eye infection or pneumonia
- Can lead to premature delivery and low birth weight

PREVENTION

Recommendations to reduce the spread of Chlamydia infection:

- Abstinence is the only sure way to prevent infection
- Always use latex condoms consistently and correctly during vaginal, oral and anal sex
- Limit your number of sex partners
- To prevent re-infection, notify all sex partners immediately to make sure they are tested and treated

TREATMENT

- Can be cured with proper medication

A PERSON CAN BE RE-INFECTED AFTER TREATMENT, SO…

- All persons whom you have had sex with during the 60 days before onset of symptoms or during the 60 days before the time of your diagnosis should immediately be evaluated and treated
- To avoid re-infection, do not have sex until you and all of your sex partner(s) are:
    - 7 days past the single-dose treatment

    OR

    - finished with the 7-day treatment

FOR MORE INFORMATION, CONTACT:

Iowa Department of Public Health
STD PROGRAM
Lucas State Office Building
321 E. 12th Street
Des Moines, IA 50319-0075
(515) 281-3031
http://www.idph.state.ia.us/adper/std_control.asp

Partner Management

Patients should be instructed to refer any sex partner(s) for evaluation, testing and treatment. The following recommendations on exposure intervals are based on limited evaluation.

Chlamydia:

- Refer all partners from the last 60 days before onset of symptoms for routine history and exam.
- Treat all partners from the last 60 days before onset of symptoms.
- If no partners in last 60 days, treat most recent partner.
- If asymptomatic, treat all partners from 60 days prior to treatment of original patient.

Gonorrhea:

- Refer all partners from the last 60 days before onset of symptoms for routine history and exam.
- Treat all partners from the last 60 days before on set of symptoms.
- If no partners in last 60 days, treat most recent partner.
- If the case is asymptomatic, treat all partners from 60 days prior to treatment of original patient.

Patients should be encouraged to abstain from sexual intercourse **until they and their sex partners have completed treatment**. Abstinence should be continued until 7 days after a single-dose regimen or after completion of a 7 day regimen. Timely treatment of sex partners is essential for decreasing the risk of re-infecting the original patient.

Expedited Partner Therapy (EPT)

On July 1, 2008, Expedited Partner Therapy (EPT), also known as became legal in the state of Iowa. EPT is legal in many cities and states throughout the United States. There are different types of EPT. Partner Delivered Therapy (PDT) is the practice of treating the sex partner(s) of persons with STDs by allowing the infected patient to deliver oral medication or a prescription script to exposed partners. Directly Observed Therapy (DOT) is the practice of treating the sex partner(s) of persons with STDs by allowing a public health professional to deliver oral medication or a script to exposed partners. Iowa law allows both PDT and DOT. The specific language in the Iowa Code for EPT is provided in the **Iowa Law and Confidentiality** section of this toolkit under **Section 139A.41 Chlamydia and Gonorrhea.**

- Studies show EPT reduces re-infection rates by about 20%.
- Studies show that providers use EPT frequently – some up to 50% of the time.
- Since repeated re-infection increases the chances of serious health consequences and the likelihood of the bacteria developing resistance to treatment, it is essential to reduce re-infection rates as much as possible.
- EPT is associated with a higher likelihood of partner notification (letting sex partners know they have been exposed to an infection) when compared to other forms of un-assisted partner management.
- EPT is associated with a significant reduction in the rates of patients engaging in continued sexual encounters with known untreated partners.
- While allergic reactions in partners treated without direct medical supervision can occur, studies indicate that the oral antibiotics used for EPT generally create mild adverse outcomes if any at all. No serious allergic reactions as a result of EPT have been reported to the CDC.
- The most commonly reported adverse outcome is mild gastrointestinal intolerance.
- Always send information about STDs and the medication you are giving with the patient to give to the partner. That way, the partner will be alerted to seek an STD screening for other infections and understand the risks of taking the medication.

IMPORTANT!

If your clinic receives public funding such as Medicaid or is supplied with publicly purchased STD medications, make sure to check the regulations for reimbursement/dispersing medication before billing for or offering medications for partners. In this situation, it is probably best to offer a script for the partner(s).

Information about EPT changes rapidly. For the most recent guidance and printable information visit:
http://www.idph.state.ia.us/adper/std_control.asp

Partner Notification Referrals

There are many different methods to perform partner notification referrals and counseling. It can be done by the patient themselves, by the provider, or by state or local **Disease Prevention Specialists** (DPS). DPS Partner Notification, also called "provider referral", is a safe and confidential way for people to locate and inform current and past partners that they may have been exposed to an infection.

DPS assisted Partner Notification is one of the best ways to stop the spread of infection and has been used with STDs for more than 30 years.

- The DPS can assist in finding people who have STDs, but may not know it.
- Iowa law allows the Iowa Department of Public Health and local health departments to offer partner notification assistance to every person with an STD or HIV.
- The decision to participate in partner services is up to each individual and is completely confidential.

A patient might need time to process the situation before being willing to proceed with partner notification.

1. Tell the patient that you will give him/her some time to think it through, and will call or see him/her in the office within the next week to discuss it again.
2. Find out how the patient wants to be contacted. Set up an agreed time, date and method (e.g. office visit, phone call, etc.) to follow up.
3. Send the patient home with information on how to access partner notification services. Schedule another appointment in 3 months to retest the patient.
4. Make a note to continue dialogue on prevention and partner notification at that visit as well.

A Confidential Partner Record helps identify the partners of the patient:

Many public clinics use the form provided on the next page to collect partner information. **HERE'S HOW:**

- If the patient is **positive**, the form can be provided to a DPS.
- If the patient is **negative**, the form can be shredded. ***PLUS…***
- The form is a good lead-in to discussing sexual health with a patient:

"I see you've had two sexual partners in the last year. What questions do you have about sexual health?"

A DPS Flyer and DPS Map are also included in the following pages and can be helpful to handout and discuss with patients during the exam.

Name: _____
Date: _____

Confidential Partner Notification

It is important that <u>all</u> the people you are having sex be tested and treated. This includes all of your partners in the last 3 months. Please fill in the form below, so that testing and treatment can be offered to them. This is completely confidential or private. Your name and information will not be shared with anyone.

1. Name _____ Male_____ Female_____
   Address _____
   Phone number(s)_____Age / birth date _____
   When did you have sex? First time_____ Last time? _____
   Where do they work or go to school? _____
   What do they look like? _____
   Have they been tested or treated? _____

2. Name _____ Male_____ Female_____
   Address _____
   Phone number(s)_____Age / birth date _____
   When did you have sex? First time_____ Last time? _____
   Where do they work or go to school? _____
   What do they look like? _____
   Have they been tested or treated? _____

3. Name _____ Male_____ Female_____
   Address _____
   Phone number(s)_____Age / birth date _____
   When did you have sex? First time_____ Last time? _____
   Where do they work or go to school? _____
   What do they look like? _____
   Have they been tested or treated? _____

4. Name _____ Male_____ Female_____
   Address _____
   Phone number(s)_____Age / birth date _____
   When did you have sex? First time_____ Last time? _____
   Where do they work or go to school? _____
   What do they look like? _____
   Have they been tested or treated? _____

Please turn the form over to list additional sex partners.

Disease Prevention Specialists

Your health care provider or other health professional is giving you this flyer to let you know who Disease Prevention Specialists are (DPS), what they do, and when you might hear from a DPS.

If you are diagnosed with a treatable sexually transmitted disease (STD) such as Syphilis, Gonorrhea, Chlamydia, or HIV a DPS from the local or state health department will follow-up with you. Health care providers and laboratories are required to report such infections to the health department to assist with disease control and prevention. The DPS will first get information from your health care provider to be sure to know how to reach you and be sure you were given the right medication. The DPS will then contact you to see if you have any questions and talk to you about the infection. This will help to ensure that you thoroughly understand the infection; know how long you may be able to spread it to other people; learn how to lower your risk of getting this and other STDs in the future; understand your prescribed treatment; and know when you need follow-up tests to ensure the treatment was effective.

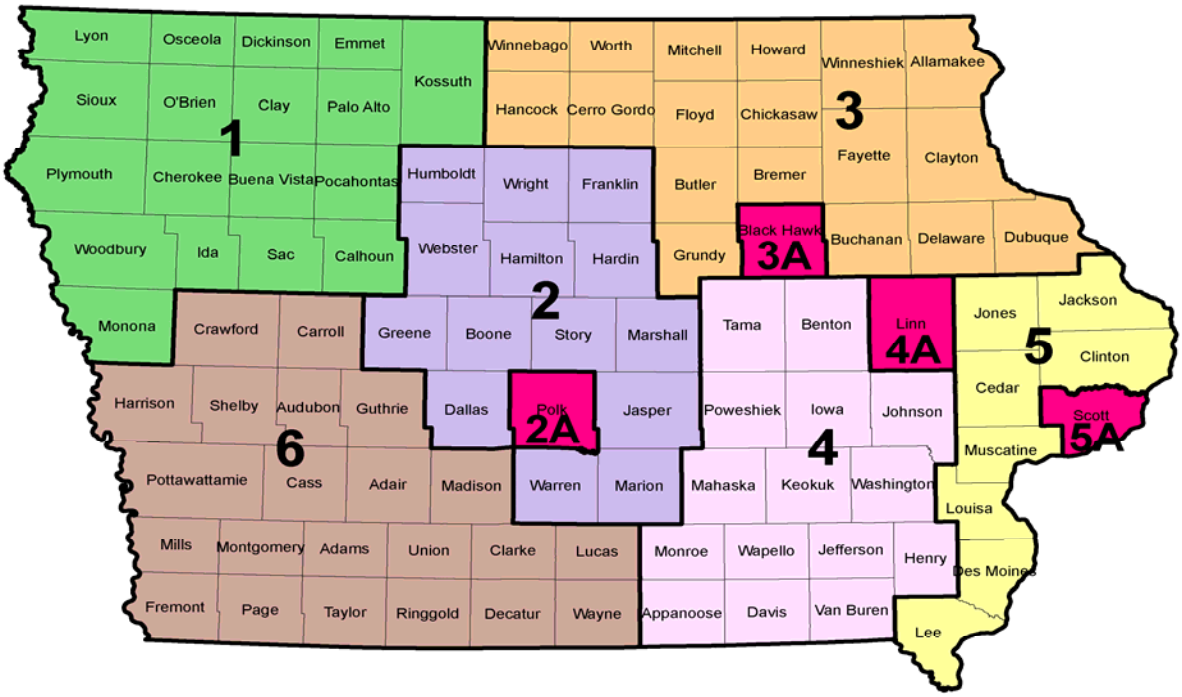
The DPS will also assist with confidentially informing all of your sex partners who may have passed the infection to you, or vice versa. It is very important that partners receive medical care to help prevent these infections from getting worse and to prevent the further spread of STDs. Testing and treating your partners also helps keep you from getting re-infected by an untreated sex partner. Most partners do not know that they have been exposed to, or are infected with an STD since people do not usually have symptoms until the infection is really bad.

DPS carefully protect confidentiality as it relates to everyone associated with the infection at all times as required by law. DPS are trained public health workers, whose job is to assist with protecting the health of the community. DPS DO NOT share any information including names with the people they talk to.

We hope the word spreads that DPS are there to help keep the community healthy. Thank you in advance for your time and help. For more information, please call: 515-281-3031 or visit www.idph.state.ia.us/adper/std_control.asp

Thank you again.

IOWA DEPARTMENT OF PUBLIC HEALTH
BUREAU OF DISEASE PREVENTION AND IMMUNIZATION
DISEASE PREVENTION SPECIALIST DISTRICTS



Area 1
Jodie Liebe
Siouxland District Health Dept
1014 Nebraska St
Sioux City IA 51105
712-234-3926
FAX: 712-255-2601
jliebe@idph.state.ia.us

Area 2
Vacant
Polk County Health Dept
1907 Carpenter
Des Moines IA 50314
515-286-3554
FAX: 515-286-2033

Area 2A
*Mary McCann
515-286-3749
*Beth Dooley
515-286-3743
*Jaimie Schwab
515-286-3742
*Kelli Wulfekuhle
515-286-3741
*Virginia Thraen
515-286-2135
Polk County Health Dept
1907 Carpenter
Des Moines IA 50314
515-286-3798
FAX: 515-286-2033

Area 3
Gina Spinler
Black Hawk County Health Dept
1407 Independence Ave 5th Floor
Waterloo IA 50703
319-292-2235
FAX: 319-291-2529
Dubuque City Health Dept
563-589-4181
gspinler@idph.state.ia.us

Area 3A
*Ann Rogers
*Brenda Ohlenkamp
*Tammy Hicok
*Tim Kramer
Black Hawk County Health Dept
1407 Independence Ave 5th Floor
Waterloo IA 50703
319-291-2413
FAX: 319-291-2529

Area 4
Shannon Wood
Mail Address:
Johnson County Public Health
1105 Gilbert Ct
Iowa City IA 52240
319-358-1834
FAX: 319-356-6039
Office Address:
321 1st St
Iowa City IA 52240
swood@idph.state.ia.us

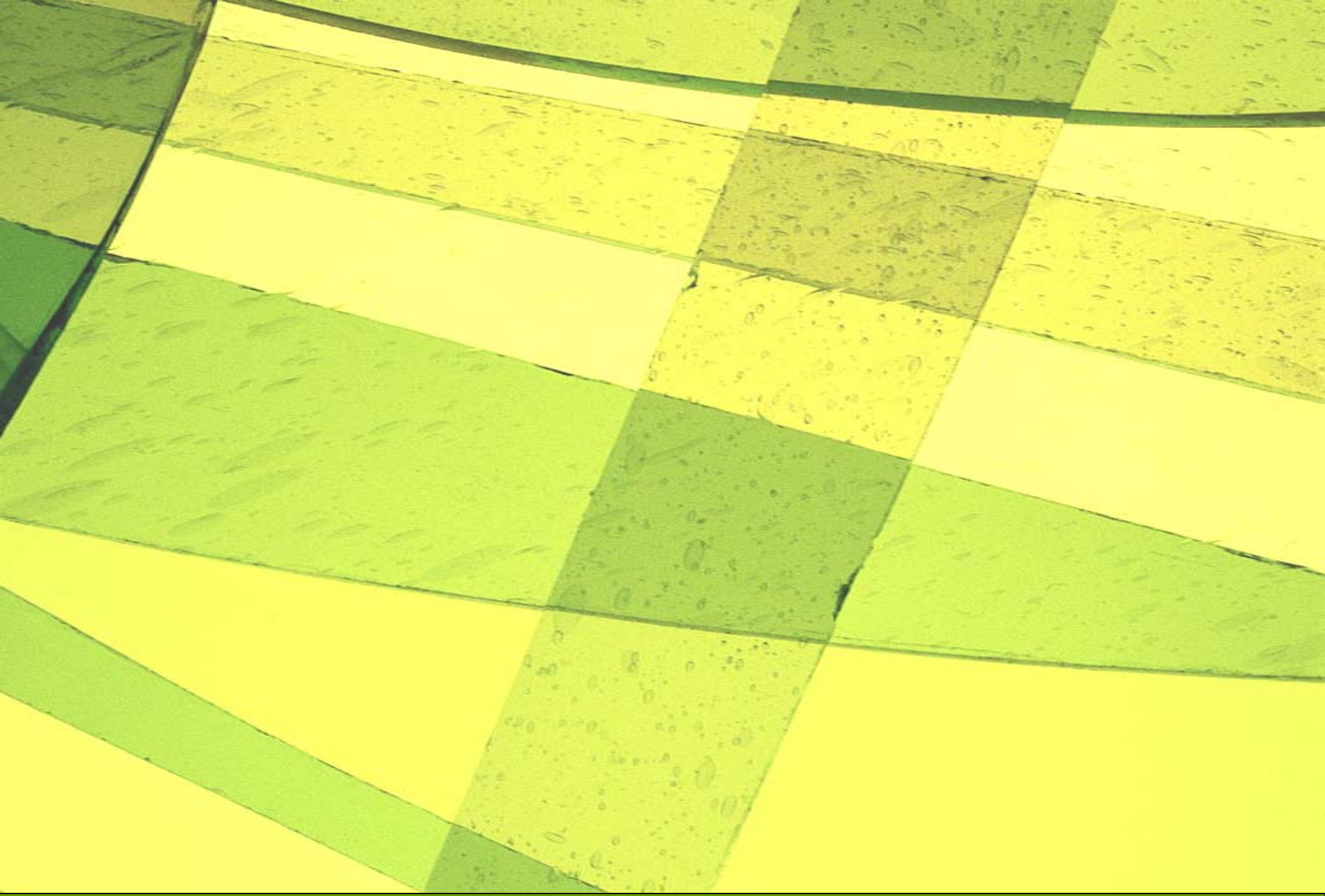
Area 4A
*Vickie Smith
*Diana Stahle
*Ferron Coutentos
*Kathy Davis
*Megan Hart
*Sherri Schuchmann
Linn County Public Health
501 13th St NW
Cedar Rapids IA 52405
319-892-6000
FAX: 319-892-6099

Area 5
Mary Costello
600 W 4th St 4th Floor
Davenport IA 52801
563-326-8216
FAX: 563-326-8774
mcostell@idph.state.ia.us

Area 5A
*Roma Taylor
*Lashon Moore
*Ann Jepson
*Jane Morehouse
*Kathleen Andresen
*Stuart Scott
Scott County Health Dept
600 W 4th St 4th Floor
Davenport IA 52801
563-326-8618
FAX: 563-326-8774

Area 6
Linda McQuinn
Council Bluffs City Health Dept
209 Pearl St
Council Bluffs IA 51503
712-328-3194
FAX: 712-328-4917
lmcquinn@idph.state.ia.us

* County Employee
Revised 08-05-08 A Bode



References and CME'S

References

(2002, November). *Chlamydia Care Quality Improvement Toolkit.* California Chlamydia Action Coalition, STD Control Branch of the California Department of Human Services, University of California – San Francisco, and Price Waterhouse, LLP.

(2004, January) – 2nd Edition. *Prevention and Management of Chlamydial Infection in Adolescents: A Toolkit for Clinicians.* University of Massachusetts Medical School, Massachusetts Department of Public Health Bureau of Communicable Disease Control Division of STD Prevention, STD/HIV Prevention Training Center of New England.

Swint, Sean, Many Teens Not Getting Necessary Medical Care, Teens at Greatest Risk Most Likely to Forgo Help, WebMD Medical News, December 14, 1999.

DR Blake et al, Improving Participation in Chlamydia Screening Programs: Perspectives of High Risk Youth, Archives of Pediatric Adolescent Medicine, 2003, June; 157(6):523-9

Dr. Gail Bernstein, M.D. (2008). *Coding for Adolescent Reproductive Health Services folder, Erie County Public Health*: 2008 Centers for Disease Control and Prevention National STD Conference.

(2006, November). *A Guide to Taking a Sexual History:* Centers for Disease Control and Prevention Syphilis Elimination Web site: http://www.cdc.gov/std/see/.

(2006) Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2006. MMWR 2006; 55(No. RR -11): 38-50.

(2006) *Expedited partner therapy in the management of sexually transmitted diseases.* Centers for Disease Control and Prevention: US Department of Health and Human Services.

Hogben M, McCree DH and Golden MR. Patient-delivered partner therapy for sexually transmitted diseases as practiced by U.S. physicians. Sexually Transmitted Diseases 2005; 32:101-105.

"STRATEGIES FOR EFFECTIVE CHLAMYDIA SCREENING" QUESTIONNAIRE

Office Name:_____ Date: _____

1. Provider Type (circle one)
   - Physician
   - Nurse Practitioner
   - Physician's Assistant
   - RN
   - LPN
   - Other _____ (Please describe)

2. Clinic Type (circle one)
   - Family Practice Clinic
   - Adolescent Clinic
   - Pediatric Clinic
   - Obstetric/Gynecologic Clinic
   - Hospital/ER
   - Other _____ (Please describe)

3. What year did you complete your specialty training? _____

4. What is your gender? (Circle one) FEMALE MALE

5. About what percent of general physical exams are your FEMALE patients given some time alone with the provider?

13 years old ____%	16 years old ____%	older than 18 years ____%
14 years old ____%	17 years old ____%	
15 years old ____%	18 years old ____%	

6. About what percent of general physical exams are your MALE patients given some time alone with the provider?

13 years old ____%	16 years old ____%	older than 18 years ____%
14 years old ____%	17 years old ____%	
15 years old ____%	18 years old ____%	

7. About what percent of general physical exams are your FEMALE patients asked about sexual behavior?

13 years old ____%	16 years old ____%	older than 18 years ____%
14 years old ____%	17 years old ____%	
15 years old ____%	18 years old ____%	

8. About what percent of general physical exams are your MALE patients asked about sexual behavior?

13 years old ____%	16 years old ____%	older than 18 years ____%
14 years old ____%	17 years old ____%	
15 years old ____%	18 years old ____%	

9. About what percent of sexually active FEMALE patients do you offer STD testing to? _____%

10. About what percent of sexually active MALE patients do you offer STD testing to? _____%

11. What STD testing do you routinely offer? (circle all that apply)

Chlamydia Gonorrhea Syphilis Herpes Trich HPV HIV

12. Were you aware of urine-based Chlamydia and Gonorrhea nucleic acid amplification tests before participating in this activity? (circle one) YES NO

"STRATEGIES FOR EFFECTIVE CHLAMYDIA SCREENING" QUESTIONNAIRE CONTINUED

13. During what types of exams do you regularly offer FEMALES STD testing? (circle all that apply)
Annual Physical during PAP Annual Physical without PAP Sports Physical When symptomatic

14. During what types of exams do you regularly offer MALES STD testing? (circle all that apply)
Annual Physical Sports Physical When symptomatic

15. Do you intent to increase the proportion of general physical exams where the following FEMALE patients are provided some time alone with the provider?
13 to 14 years old (circle one) YES NO
15 to 19 years old (circle one) YES NO
18 years and older (circle one) YES NO

16. Do you intent to increase the proportion of general physical exams where the following MALE patients are provided some time alone with the provider?
13 to 14 years old (circle one) YES NO
15 to 19 years old (circle one) YES NO
18 years and older (circle one) YES NO

17. Do you intend to increase the proportion of general physical exams where the following FEMALE patients are asked about sexual behavior?
13 to 14 years old (circle one) YES NO
15 to 19 years old (circle one) YES NO
18 years and older (circle one) YES NO

18. Do you intend to increase the proportion of general physical exams where the following MALE patients are asked about sexual behavior?
13 to 14 years old (circle one) YES NO
15 to 19 years old (circle one) YES NO
18 years and older (circle one) YES NO

19. Do you intend to increase the proportion of sexually active FEMALE patients to whom you offer an STD screening? (circle one) YES NO

20. Do you intend to increase the proportion of sexually active MALE patients to whom you offer an STD screening? (circle one) YES NO

21. If you answered "yes" to #19 and/or #20: What STD testing do you intend to offer more frequently? (circle all that apply)

Chlamydia Gonorrhea Syphilis Herpes Trich HPV HIV

22. Do you intend to increase the proportion of Chlamydia and Gonorrhea nucleic acid amplification tests that you order? (circle one) YES NO

23. Can we contact you in 2 to 3 months to enquire about your changes in sexual health care practices? (circle one) YES NO

"STRATEGIES FOR EFFECTIVE CHLAMYDIA SCREENING" QUESTIONNAIRE CONTINUED

24. This activity fulfilled the stated CME objectives. (circle one) YES NO

25. The sections were effectively written. (circle one) YES NO

26. How could we have improved the activity?

27. What CME topics related to STDs would you like to see in the future?

Designation Statement: The Saint Louis STD/HIV Prevention Training Center designates this educational Activity or a maximum of 2.0 AMA PRA™ Category 1 credit. Physicians should only claim credit Commensurate with their participation in the activity.

Name: _____ License Number: _____

Address: _____ License State: _____

City/State/Zip: _____ Credentials: _____

Phone: _____ E-mail: _____

I confirm that I participated in the session "Strategies for Effective Chlamydia Screening". _____

Signature of Participant

Send the completed CME Questionnaire to:

Deloris Rother, MPH, Manager
Prevention Training Center
St. Louis STD/HIV Prevention Training Center
Washington University School of Medicine
660 S. Euclid Avenue, Campus Box 8051
St. Louis, MO 63110-1093
Telephone: (314) 747-0294
FAX: (314) 362-1872
Std/hiv@im.wustl.edu

A certificate of credit will be mailed to you.
Retain a copy of your certificate for your records.
This activity was reviewed on August 22, 2008.
The expiration date for this activity is September 1, 2009.